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ABSTRACT

The inaugural volume of this serial contains 12 articles that represent a diverse population of counselors: (1) "Issues in Counseling Immigrants" (Linda Sheppard); (2) "Family Support and Starting a Small Business" (Michael Cusack and Peter Emerson); (3) "Professional Disillusionment: Crisis or Catalyst" (Kay Miller, Susan Cooper-Shoup and Kimberly Jarreau); (4) "Adult Survivors of Child Sexual Abuse: Identifying and Developing a Creative Treatment Plan" (Patrice Moulton and Kimberly Newell); (5) "Young Adults and AIDS: A Support Group For HIV Positive Women" (Bernadette Mathews and Lee Rigby Robinson); (6) "Adults Returning Home: Issues and Interventions" (Peter Emerson); (7) "Intimacy From a Lifespan Perspective" (Carolyn Cavanaugh); (8) "Career Counseling with the Middle Age: A Group Counseling Model" (Larry Burlew and Connie Fox); (9) "Bridging the Gap between the Psyche and the Soul" (Patricia J. Price); and (10) "Self-Efficacy and Adult Women" (Patricia Y. Leonard). The "Practically Speaking" section includes the following articles: (1) "Chrysalis Shelters: A Family Violence Treatment Program" (Michelle Dosch, Jeanette Paasch and Leah Bernstein); (2) "Individual vs. Group Identity: A Counseling Perspective" (Stephen Flemming). The articles include a list of selected references. (BF)

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VOLUME I SPRING, 1989

MONOGRAPH:

YOUNG ADULTHOOD AND MIDDLE AGE

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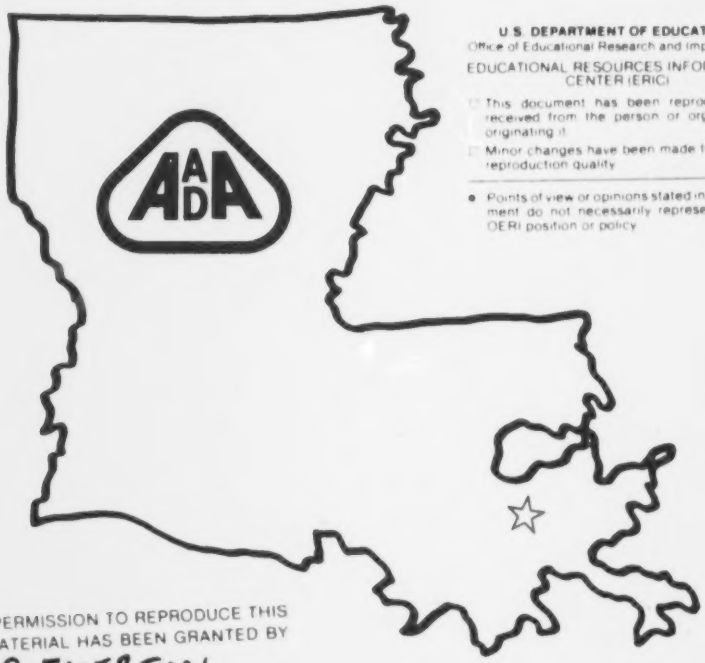

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FROM THE EDITORS

To promote participation in the initial Association for Adult Development and Aging (AADA) National Conference on Young Adulthood and Middle Age, every effort was made to secure articles and presentations from as diverse a counselor population as possible. Conference announcements and calls for papers appeared in the Guidepost, The Career Planning and Adult Development Network Newletter, and Lagniappe (Louisiana Associations' offical newsletter). Results have been extremely positive in terms of the number and quality of proposals submitted.

The articles selected for publication varied in length and content. Two categories, articles and practically speaking, were used to allow inclusion of the variety of materials submitted. Each of the articles were selected because of their viable contribution to the counseling professional working with the young adult and middle aged populations. We also believe you will appreciate the timeliness of the selections as many of the presentations are on the forefront of future counseling techniques.

The editors have enjoyed the challenges and results of working on this publication. The experience has enabled us to develop innovative ideas for next year which we hope will prove exciting to you, and stimulate even greater participation. We hope the final products, both the monograph and the conference, are of benefit to all counseling professionals. We appreciate, and thank those who have taken time to submit materials and present ideas at AADA's first annual conference on young adulthood and middle age entitled "Young Adulthood and Middle Age: A Counseling Perspective."

Larry Burlew
Peter Emerson

CAREER PLANNING WITH IMMIGRANTS AND REFUGEES

Linda Sheppard

During the early 1900's Frank Parsons' work with America's first great wave of immigrants became the foundation of the career counseling profession (Gummere, 1988). In 1989 a number of combined factors have resulted in a renewal of professional interest in facilitating immigrant and refugee career development.

America is experiencing its second greatest wave of immigrants. Predominately Hispanic and Asian rather than European, these populations are predicted to double by the year 2000 (Johnson & Packer, 1987). Through the amnesty program more than two million illegals have become eligible for education and services. Hoyt (1987, 1988) indicates that at a time when America is moving from an industrial to a service, information-oriented, and high technology society, over a third of new jobs will require some form of post-secondary education. Additionally, workers will need to possess the flexibility to adapt to changing job requirements as many as five to six times in their careers (Brock, 1987). Because many immigrants and refugees come from situations where education was interrupted or denied or possess nontransferable work skills (Gordon & Friedenberg, 1988), they will be less well prepared as technological changes require increased skill levels. Immigrants will be underrepresented in high growth occupational areas and overrepresented in areas experiencing low growth (Arbona, 1989; Hoyt, 1988; Rockett, 1980).

Traditionally, the focus of immigrant vocational programs was on obtaining a "job" rather than on reestablishing a "career" in an "occupation" congruent with an individual's interests and skills (Gordon & Friedenberg, 1988; Tollefson, 1985). However, research since 1980 on programs for Southeast Asian refugees found that job skills training and placement services apparently had only limited

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effect on employment (Strand, 1984; Tollefson, 1985). A study by Anh and Healy (1985) discovered that Vietnamese refugees as a group "had surprisingly negative views about the methods and resource people involved (with placement services)" (p. 82) and resented being directed to jobs and training at levels below what they expected.

The purpose of this article is to review studies of immigrant and refugee vocational adjustment from a career development perspective. While still incorporating Parson's (1909) model---helping an individual make appropriate decisions based on knowledge of self and the work world, career choice is defined as an expression of needs and an implementation of self-concept over the life-span as an integral part of personal adjustment (Crites, 1981, p. 119). This review includes a discussion of the impact of immigration on career development and the influence on career success and satisfaction of factors unique to the immigrant and American experience. The article concludes with a framework for providing career services.

The Impact of Immigration

The career problem of immigrants "is not only adjusting to the company they work for but, at the same time, adapting to a new society while going through a process of integration...in a new environment" (Krau, 1982, p. 314). First described by Oberg (1960) as "culture shock," immigration is a crisis disrupting developmental processes and demanding reworking of earlier developmental tasks. It involves the loss of the "average expectable environment," a "complete disorganization of the individual's...cognitive map" (Cohon, 1981, p. 261). Through a process of resocialization the immigrant develops a new occupational identity as part of a new social identity.

Social Identity Development

During the first several months in a new country, immigrants are initally concerned with basic needs and have a feeling of euphoria. This is followed by "psychological arrival" in which the person "increasingly recognizes the differences in customs, becomes aware of his or her losses, and idealizes the past" (Cohen, 1981, p. 257). Symptoms of suspiciousness and paranoia, depression, and somatic complaints as well as feelings of insecurity, isolation, resentment, guilt, anxiety, inadequacy, and bereavement occur during the first year. Eventually problems related to socialization may decrease, although depression and other problems related to health,

family relationships, and employment continue. Many refugees who have suffered traumatic experiences related to war and flight have symptoms of post traumatic stress syndrom, as well as survivor's guilt and grief (Arredondo, 1986; Firling, 1988).

Arredondo (1986) proposes that immigration is an historical moment causing "a recapitulation of the life-cycle tasks" of ego development as proposed by Erikson (p. 80). An immigrant must progressively resolve issues related to feelings of distrust of an unfamiliar environment, embarrassment and humiliation at being "different," guilt from surviving, and inferiority from low status employment. Reestablishment of an acceptable work identity contributes to the sense of confidence and esteem that is necessary in avoiding identity confusion.

Seymour Adler (1977) suggested using Maslow's need hierarchy to describe the evolution of needs in the immigrant adjustment process: "no matter which level of hierarchy their personality development had reached prior to emigration, they are pushed by various factors toward the bottom of the hierarchy" (p.445). Only after gratification of physiological and security needs will the immigrant be interested in developing new social contacts or finding challenging work. With his Israeli immigrants Adler found that housing was important initially, social needs surfaced around twelve months, and work was important at the end of the two years. Although a "job" is immediately important to satisfy physiological and security needs, a "career" becomes important only after the initial crisis of adjustment has been resolved.

Taft (1973) described this resocialization process as predictable and linear but not necessarily occurring in all aspects or to the same degree in all immigrants. An immigrant may "adapt," making changes in physical appearance, behavior, or attitude to better fit the new environment, "adjust" with feelings of harmony with the environment though values and attitudes may be different, or "integrate" into various social and economic groups. Employment is a "critical factor in moving the refugee into the mainstream of society" by restoring a sense of "self-regard" and by providing opportunities to practice language, learn social norms and develop secondary social and professional networks (Stein, 1979, p.27).

Minority Identity Development

Banks (1979) believed that resocialization is not necessarily linear because it may also entail the development of a minority

identity. In Banks' model the initial stage is one of "conformity" or "ethnic psychological captivity" in which the minority person internalizes negative stereotypes about his or her own ethnic group and identifies with the dominant culture. As knowledge of the culture increases conflict may occur. This dissonance may lead to "resistance and immersion" or "ethnic encapsulation" in which there is interaction only with members of the ethnic group which is believed superior to the dominant culture. A period of "introspection" or "ethnic identity clarification," in which aspects of both cultures are questioned, may eventually lead to an awareness of and respect for the positive aspects of both cultures, "biethnicity" or "multiethnicity." The reference group is the original ethnic group but the person appreciates and possesses skills to participate in both cultures. In describing the acculturation of Hispanics, Ruiz (1981) cautions that individuals may vary along a continuum from "very Hispanic" to "very Anglo" (p.199). Attitudes toward language aquisition, training programs and counselor ethnicity and race will vary according to the individual's stage of resocialization and minority development.

Career Development

Edgar Krau (1982) suggested a developmental model of immigrant career adjustment based on models of theorists such as Donald Super. Immigrant adults, who in their country of origin are in establishment or maintenance stages, revert to earlier phases (e.g., trial or crystallization) in the new country. They redo earlier tasks in the form specific to the new work environment and to the immigration experience.

Each career stage reflects coping behavior with specific career developmental tasks. Career reconstruction becomes a continuous process again in which the successful acquisition of skills in one stage serves as a predictor for successful coping in the next stage. Immigrants go through career stages regardless of their chronological age. They "have no time for prolonged crystallization and tryouts. Their aim is to arrive, as quickly as possible, to the establishment stage 'occupational persona'" (Stefflre, 1966 in Krau, 1982, p. 315). They must adjust their vocational self-concept to reconcile the incongruence between past and present social status, vocational knowledge and experience.

Krau's five stages are reproduced in Table 1. These stages are similar to those of people who change careers for whatever reason, but language difficulties and the need to learn and adapt to a new

culture affect coping behaviors and length of the stages. Of the variables tested as success predictors of each stage, those that proved more important than others are starred (*). Krau concluded that most immigrants must go through these stages, including some stage of retraining. Even if an immigrant is able to continue a previous career, each country will have its own procedures and customs requiring retraining. A separate stage of job entry and trial is necessary, "not so much because the person has difficulties in making a firm decision regarding his job preferences, but because this is a unique moment the newcomer must prepare for, and it relies on special traits and skills" (Krau, 1982, p. 329).

Finnan (1981) described the role of the ethnic community in shaping the occupational identity of the immigrant. Friends and family encourage immigrants to mold their sense of self to fit the occupational role while also helping to shape their image of the job consistent with their needs. In the Vietnamese community, the job of electronics technician was viewed as middle class, conducive to socioeconomic advancement, demanding male skills, and appropriate for the special problems of refugees (Finnan, 1981, p. 295). Vietnamese men were encouraged to see themselves as possessing the skills, limitations, interests and cultural attitudes consistent with job demands, and as middle class and financially responsible for themselves and their families. The status of a job is defined within the ethnic community, not the dominant culture. "It is a good job for me" because the community says "It is a good job for us Vietnamese" (Finnan, 1981, p. 295).

Career Success and Satisfaction

Ultimately "satisfaction in work and congruence with the work environment....[are] the criterion of objective adjustment which reflects vocational maturity" (Krau, 1982, p. 314). Occupational success can be determined by employment status and mobility or satisfaction by self-report. Both are affected by premigration characteristics and by barriers and enabling factors inherent in the specific American experience of each immigrant.

Downward Mobility

Labor force participation rates for immigrants and refugees are only slightly lower than those of the general population. In Strand's (1984) study of 800 male and female Indo-chinese household heads over a six year period, over 50% were employed by the end of two years and 93% at the end of six years. Employment, however, is

Table 1

Krau's Career Development Model

Career stage	Problem-creating condition	Coping behavior	Variables tested as success predictors
Crystallization	Language difficulties Lack of information on labor market & on job requirements	Learning Help seeking behaviors	Learning achievement Bid to be admitted to training program *General attitude toward work Interest in new occupation *Self-assertion
	Cognitive dissonance over status incongruence	Reducing cognitive dissonance	Lowered vs unchanged *(Job involvement) *(Social skills)
Vocational retraining	Cognitive dissonance over status incongruence	Reducing cognitive dissonance	*Self-assertion
	Need to accept unfamiliar occupation Lack of skill in new occupation	Emotional acceptance of new occupation Acquisition of occupational knowledge and skills	*General attitude toward work *Vocational involvement *Valuing of money Learning aptitudes *Vocational aptitudes Acquisition of initial skills in new occupation
Job entry and trial	Competition on the labor market Short employment interviews & tests	Competitive behavior Efficiency in test situations and display of vocational knowledge and skills	*Boldness *Social skills Vocational knowledge & skills Vocational aptitudes
Establishment	Job requirements New work community Need for enculturation Need for economic security	Conforming to requirements Openness to social contacts and new values Effort to achieve a permanent income	*Vocational aptitudes *Vocational knowledge & skills *Vocational involvement Social skills *Valuing of money *Positive attitude toward work Location of employment
Maintenance	Job requirements Need to heighten living standard & position in community	Conforming to job requirements Effort to catch up economic community standards Effort to assert oneself in the community	(Vocational skills) *Vocational involvement *Valuing of money Social skills *Self-assertion

from: Krau (1982, pp. 318-319, 327)

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usually of lower status. In a study of male and female Indo-chinese refugees by Stein (1979) initial employment reflected a severe drop followed by a few years of upward mobility. However, this effort was not enough to regain previous status. Stein suggested that the initial motivation to regain previous status waned as time passed in the face of continued difficulties and upward mobility slowed. After 27 months in the U.S., the majority of Vietnamese were dissatisfied with their work because it was "temporary, not in line with their training, too demanding, and had no possibility for advancement" (Stein, 1979, p. 28). After three or four years, the refugee had "finished the major part of his occupational adjustment and is likely to be at or near his permanent position in society. Little occupational change occurs after this point" (Stein, 1979, p. 35). The refugee is getting older, skills are becoming stale, and family concerns become priorities. Refugees focus their hopes on their children. Of those who do reenter their previous occupations, blue collar workers generally recover in one to two years while technical and professional workers take longer. At the end of ten years the refugees as a whole were settled in occupations with lower status than they originally had. Stein, (1979) noted that exceptions to this pattern were unskilled workers who participated in vocational training programs, young refugees profiting from an education in the U.S., or refugees establishing their own businesses (pp. 42-45). Stein concluded that career assistance programs needed to be concerned with the first years of refugee residence that appear so crucial in establishing career direction and vocational adjustment.

Rockett (1980) investigated the relationship between education and short term (5 year) occupational mobility of white, Asian, black, and Spanish male employed immigrants using the 1970 Census records. Average residency was 2.5 years. While Asians were the most educated (over 40% posessing some college graduate work), blacks and Spanish were least educated (almost half of the 35-64 age group with only an elementary education). For all except the Spanish population, there was a direct relationship between education and occupational mobility as indicated in Figure 1. Rockett hypothesized that language proficiency--the non-Spanish immigrants "were born in countries where English is a major language"--as well as actual completion of either high school or college impacted on mobility (p. 26). Highly educated immigrants may possess greater transferability of skills as well as greater familiarity with English and American culture and society, such as the Asian Indian immigrants described by Sodowsky and Carey (1987). Also, whites may have greater upward mobility due to

"greater sociocultural congruence" and "immunity to racial discrimination" (Rockett, 1980, p.29).

Finnan (1981), however, suggested that downward occupational mobility is not a concern if the opinions, attitudes and information within the ethnic community give the job status. Counselors must be aware that refugees and immigrants filter their perceptions through a cultural lens. Jobs a counselor may not think suitable may be approved by and appropriate to the community. While a first survival job may be of any type, subsequent jobs may reflect perceptions of the community. Finnan suggested that counselors encourage refugees to delay long-term career decisions until they understand the American occupational market and have some work experience and language fluency. Immediate training may be in an occupation unsuited to their interests, their eventual geographic area, or to community values.

Restricted Work Environments and Levels

Information on career patterns using job classifications and educational or economic levels indicates that immigrants find work in restricted occupational environments based on previous educational attainment, language factors, and transferability of degrees or skills. In Rockett's (1980) study, whites and almost three-fifths of the Asians were concentrated in professional and technical occupations, Spanish in the managerial category, and blacks in the service area. Both blacks and Spanish were also grouped in clerical occupations. In an examination by Arbona (1989) of 1980 Census data using the Holland typology of work, Hispanics were disproportionately grouped in Realistic and Conventional categories in jobs requiring lower education achievement, 71% of the men in Realistic and 72% of the women in Realistic and Conventional. Skilled or semiskilled occupations requiring limited formal education transfer well. Both the Hispanics in Spero's (1985) study and the Vietnamese in Stein's (1979) study were predominatly blue collar.

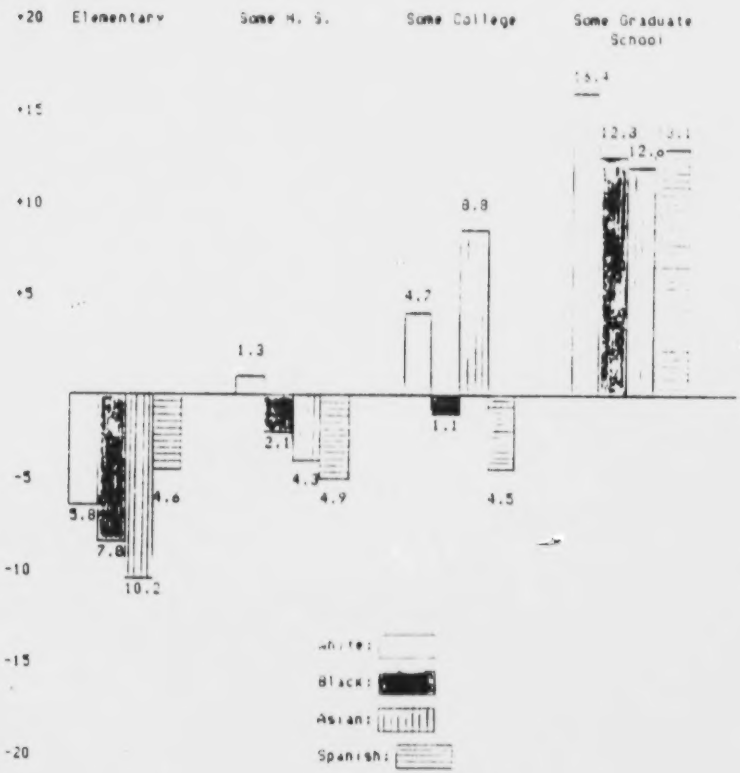
Factors Affecting Occupational Adjustment

Table 2 summarizes the major factors affecting occupational success and satisfaction of United States immigrants and refugees. Goldlust and Richmond (1974) traced the relationship between pre-migration characteristics and conditions and situational variables in the receiving society. The immigrant's educational level and technical training, language fluency, prior urbanization, age on

Figure 1

SHORT-TERM OCCUPATIONAL MOBILITY BY RACIAL-ETHNICITY

AND EDUCATIONAL ATTAINMENT



Adapted from Rockett, I. (1980), Table 3, p. 28, from 1970 Census data, N = 644. (Adjusted deviation prestige scores using Treiman's scale developed to permit international occupational prestige comparisons)

arrival, family responsibilities, and reasons for immigration interacted with the demographic makeup/similarity of the region and its degree of urbanization and cultural pluralism. Length of residence interacted with both. Career adjustment is primarily determined by years of education and post-secondary qualifications. Other positive influences are English fluency, cognitive acculturation, social mobility, length of residence and low age of arrival.

However, Taft (1973) indicated that a personal satisfaction is based on what an individual wants out of life, and these wants, or needs will differ for each individual and will also differ over time. Thus lack of language fluency may be extremely frustrating for an educated immigrant but only mildly so for an unskilled laborer. Motive for immigration also affects satisfaction. Someone who moves as part of a family may be satisfied as long as the "family" is happy. Refugees are generally initially satisfied simply because they are alive and safe. However, a voluntary immigrant seeking greater satisfaction of some sort emigrates based on his expectations of the "cost" of making the move. Determining career satisfaction or adjustment depends on the perceived needs of the individual at a particular point in his or her life.

Previous authors cited (Anh & Healy, 1985; Arbona, 1989; Rockett, 1980; Spero, 1985; Stein, 1979) describe the diversity of ethnic, educational, occupational and personal backgrounds American immigrants and refugees possess. Many have the typical handicaps of language problems, little formal education and lack of information about the U.S. job market. They may be illiterate in their own language, lack awareness of Western culture, and have job skills not easily transferable to an industrialized society. Others have high level skills, education and occupations. Non-recognition of degrees and skills and governmental, trade union, and professional licensing restrictions handicap prospects for resuming previous careers. Although many have access to traditional support resources--relatives, established ethnic communities, or resettlement agencies of similar ethnic and religious backgrounds, many are scattered in areas lacking support networks.

Logistic problems, governmental bureaucracy and an attitude of hostility by Americans increase pressure on these refugees to become independent quickly. Refugees, even more than immigrants, are unprepared for emigration, do not have papers in order, have had no opportunity to learn English, and do not have support systems in place. Years of warfare and flight have caused psychological and

Table 2

PREDICTORS OF EMPLOYMENT SATISFACTION

PREMIGRATION CHARACTERISTICS

- * Education/Training Achieved in Home Country
  International Mobility of Original Skills
- * Prior Urbanization, Cultural & Language Similarity
- * English fluency
  Motivation for emigrating (refugee or voluntary immigrant?)
  Sex and Age, Level of Isolation
  Family size, Position in Family
  Physical, Mental Health
  Personality Factors (ego strength, frustration tolerance)
  Existing Coping Methods
  Level of Preparation for Immigration (Papers, etc.)

BARRIERS TO ADJUSTMENT AND SATISFACTION

- Disparity in Cultures, Languages, Levels of Development
  Lack of Established Ethnic Community, Family (or Separation from)
  High Expectations (based on previous employment, lack of information)
  Non-recognition of Degrees, skills, licensing & other restrictions.
  Lack of Information about Job Market
  Lack of Job Search Skills
  Physical and Mental Health Concerns
  Pressure to Enter Job Market Quickly
  Resettlement & other Gov't Policies (Health care, etc.)
  Conditions of Local Economy
  Lack of transportation, childcare

ENABLING FACTORS IN NEW COUNTRY

- Length of Residence in United States
  Established Ethnic Community, Available Networks, Family
  English Proficiency: Participation in ESL Courses
  Education, Retraining received in United States
  Job Search & Skills Training
  Help in Eval., Authenticating Degrees, Skills
  Perceived Health Status, Effective Health Care
  General Coping Skills, Problem Solving Techniques, Training
  Automobile Ownership, Available Transportation
  Childcare
  Good Condition of Local Economy/Jobs Available

* Only consistently mentioned premigration characteristics. Strand (1984) concluded that only enabling, not predisposing skills, were predictors of adjustment.

Based on: Ann & Healy (1985), Goldlust & Richmond (1974), The Hmong Resettlement Study (1984), Spero (1985), Stein (1979), Strand (1984), & Tollefson (1985).

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medical problems (Cohen, 1981; Firling, 1988; Wehrly, 1988). Many resettlement agencies are only concerned that the refugee obtain any job to become self-sufficient and are not concerned with finding employment matching the refugee's background.

Many recent immigrants are, or become, female heads of households with special problems in addition to those listed above (Spero, 1985). Many come from cultures in which women receive minimal education, are illiterate in their own language and possess few job skills. Some job training programs have excluded them. Many older (over 40) women are isolated in the home. Women need access to child care and for women of many cultures the whole area of child care presents conflict. For some women faced with these obstacles, welfare policies, especially those connecting medical care to cash payments, constitute a disincentive to work.

The barriers to job satisfaction listed by refugees include difficulties with English, lack of job skills, lack of job information, scarcity of suitable jobs, inadequate transportation, and feelings of isolation and discouragement (Anh & Healy, 1985, p. 80-81). Strand (1984) reported that over 90% of those employed drove a car to work, while 50% of those unemployed cited transportation as a problem. While English proficiency was not related to employment status in Strand's (1984) study, it was correlated with high job satisfaction, and is the most often mentioned predictor in most of the other studies previously cited. The use of job skills training programs and placement services was not significant to employment (Anh & Healy, 1985; Strand, 1984). Strand concluded from his study that the "lack of significant relationships between employment status and the predisposing variables provides encouraging evidence that employment status in the U.S. is determined by enabling variables and not by conditions that were determined prior to arrival" (p. 62).

A Framework for Counseling

Table 3 presents a hierarchical framework for career counseling with immigrants and refugees. This framework incorporates the stages of resocialization, need satisfaction and identity development as well as the tasks involved in career reconstruction. Essentially immigrant and refugee career development parallels (i.e., is both part of and facilitator of) social development. As previously cited studies indicate, all newcomers must redo earlier tasks and rebuild career and social identities. The assumption implied in this framework is that individuals must successfully accomplish the basic readiness tasks at

the base of the hierarchy before they can negotiate more complex career choice tasks. Counselors must determine which tasks have been accomplished in order to determine with the client appropriate career development goals and strategies. Amnesty applicants and illegals, for example, may have been in the United States for ten years, be knowledgeable about many aspects of American life and work, yet be illiterate in English and at earlier stages of career development and resocialization.

There are no age parameters. Time spans based on previously cited studies are given for each stage as possible guidlines, but the speed with which individuals accomplish these tasks depends on personal and cultural factors and conditions in the person's new environment. Anh and Healy (1985) also suggest that "refugees need time to become immigrants" (p. 78), to commit to their new country rather than on returning to their home country. Career counseling and educational and training programs may initially be rejected by an immigrant or refugee but should be offered again after initial survival needs are satisfied. This is especially important because the previously cited studies of career patterns suggest that career direction will be determined within the first two to four years. Once established, whether immigrants and refugees can or would want to summon new energy to invest in career rather than family or social needs is questionable.

Conclusion

The primary goal of the career counselor must be to reach out to immigrants and refugees and respectfully help them use their cultural and personal backgrounds to start over. Career counselors can participate within the community, go to the immigrant through use of bilingual/bicultural peer staff and by involving the community leaders in the planning and implementation of programs (Arredondo, 1986; Harrison, 1986; Koschmann, Tobin, &Friedman, 1981). Counselors can encourage job acquisition and career planning regardless of English skills while encouraging continuing education and while helping immigrants and refugees learn to use on-the-job experience to improve their English and career skills (Gordon & Friedenberg, 1988; Harmon & Robinson, 1981; Harrison, 1986).

Counselors can broaden their view of career counseling. They might act as coordinators and advocates not only for educational and vocational programs but also for social service, mutual assistance and mental health agencies for supporting immigrants in various day to day needs so that career goals can be met (Arredondo, 1986;

Table 3

IMMIGRANT CAREER COUNSELING FRAMEWORK

INDEPENDENCE: Actualization Needs 3/4 years - 8 years

Krau's Maintenance Stage — Provide follow-up counseling & training

GRADUAL AUTONOMY: Esteem, Identity Needs 18 months - 3/4 years

Krau's stages: vocational retraining, job entry & trial establishment — Continue previous supportive services as needed

Facilitate Career Development:
- Build career personae
- Promote secondary networking, connections outside ethnic community, social extroversion, "boldness"
- Develop interview, employment test skills
- Provide: job clubs, placement, employer counseling & training

REINTEGRATION: Affiliation Needs 6 - 18 months

Krau's stages: crystallization, vocational retraining — Build sense of competence, connectedness; Continue supportive services

Facilitate career development:
- career exploration
- career planning
- vocational training, recertification implementation

Develop social skills: ESL/enculturation/support "classes"; primary & secondary networking

INITIAL CONTACT: Safety/Security Needs Under 6 months

Build Trust, Autonomy, Initiative — Bilingual prevocational services: Assessment: native language, English, education, occupation, skills recertification; Orientation to U.S work world

Coordinate supportive services and assistance:
- "Survival Job" or welfare,
- housing, food, medical, legal,
- childcare, transportation

Provide:
- Acculturation & survival skills training
- ESL/bilingual remedial skills
- Responsive counseling: survivor's guilt, trauma, anxiety & depression
- Access to extended family, ethnic network

(Utilize bilingual/bicultural staff and programs)

Stages based on Adler, 1977; Arredondo, 1984; Krau, 1982; Harmon & Robinson, 1981, and Tait, 1973.

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Wong, 1983). Help in authenticating degrees, contacting employers, entering job training or internship programs and finding refresher courses are suggested (Anh & Healy, 1985; Harmon & Robinson, 1981). Salomone (1988) suggests that career counselors need to become involved with implementation of career plans, developing job seeking skills and job placement and in post-employment or follow-up services, training employers and helping the individual adjust to the work environment. While generic to rehabilitation counseling, this model is also appropriate to career counseling with immigrants.

Many questions need to be answered regarding career counseling with immigrants and refugees. Would "career" versus "employment" assistance programs help established as well as new immigrants and refugees? What methods and programs are effective with different ethnic populations? Where, when, and by whom should services be implemented? When an increasing part of our labor force will be foreign-born, it is time to look more closely at how counseling professionals can facilitate continuing immigrant and refugee career development.

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FAMILY SUPPORT AND STARTING A SMALL BUSINESS

Michael Cusack
Peter Emerson

An increasingly popular career option for young and middle-aged adults is that of small business ownership. Individuals no longer feel the same obligation to an employer (Albanese & Van Fleet, 1983) as did adults of years past. Likewise, this age group is far more likely to abandon non-stimulating employment (Renwick & Lawler, 1978) for work that will be challenging. Today's young and middle-aged adults are more apt to make a career transition, especially the young adults (Kaplan, 1988), and more of them are making the transition from being employed to self-employment in the form of small business ownership. The phenomenon is attested to by the fact that over 98% of today's enterprises (Small Business Administration [SBA], 1988) are small businesses.

Issues of concern to individuals involved in small business should be of vital interest to each of us. Indeed 37% of the nation's work force (SBA, 1988) is influenced by individuals in small business management positions. As a result, family problems involving those individuals in small business management positions and their ability to resolve problems of such a nature will have a direct impact on each of us.

Families are a key element in the success and failure of small business according to Kepner (1983) in studies of family systems in relation to the impact the firm had on the family. His conclusion that the adaptability of the family support system was more important than the problem encountered (Kepner, 1983) emphasizes the linkage between the family and success for the small business.

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Because families in small businesses are such an integral part of the overall national economy, it seems incredulous that a review of the literature reveals such a scarcity of information. Paradoxically there is no shortfall of problematic concerns confronting individuals and their families contemplating small business ownership. This is attested to by a phenomenal 70% failure rate (Schaefer, 1981) within a period of three to five years of the initial venture into small business ownership.

Based on the evidence provided by Kepner's work a questionnaire was developed to evaluate the impact of family support systems on the small business. Reciprocal effect was also a consideration. This preliminary work focused on the identification of specific problem issues that impact the family support system attributable to starting a small business. In addition to the specific problem issues, types of family support were explored. Identifying factors of support and issues confronting the small business, family support system provides a vital first step in the creation skills. Such information and skill building is essential to enable counselors to effectively assist the individual and his/her family contemplating a transition into small business ownership.

The Questionnaire

The questionnaire was designed to provide data on the factors of support and issues confronting family support systems of the small business owner. The first step was to determine a functional definition of exactly what constituted the family support system. While there is little argument concerning the immense impact a family system has upon the individual (Clarke & Clarke, 1976) there is considerable conflict on defining the family system, which Santruck (1987) refers to as "a hodgepodge of family structures." For the purpose of this study the definition of the family system was confined to spouse, children, parents and siblings.

Administration of the questionnaire was conducted at a regional business exposition. A qualified selection of the pool of two hundred participants at the exposition was secured. This resulted in a final sample of thirty-seven respondents. The stipulations for selection in the study were: (a) first, that the participant must be currently an owner of a small business or have formerly owned a small business, and (b) secondly, the participant must fall within the parameters of eighteen to sixty years of age when they made the transition into small business.

The questionnaire consisted of twelve multiple choice questions designed to identify: (a) age, (b) sex, (c) types of support given the individual and the source of that support within the family system, (d) stresses associated with the small business venture, (e) family relationships during the initieal phase of starting their own business and currently, (f) resources the individual vitalized both family and non-family (counselor, clergy, etc.).

Respondents Profile

All of the respondents met the criterion of either currently owning/managing (34) or having owned/managed a small business (3). There was no clustering of how long the individuals has been in business as they were dispersed evenly among the four categories of less than one year, one to three years, three to five years and more than five years. The predominent category for type of business was service accounting for 62% (23) of the total study. A preponderance of the respondents were male 62% (23). The most popular age for starting a small business was the thirty to forty age group which was interesting in light of Kaplan's (1988) statement that young adults are more likely to make career transitions. In fact the forty to fifty age category tied the young adults for second as the most popular age range for starting a small business.

Results

There were many identified stressful issues that were surprisingly consistent with those associated with tradition marital counseling (Fenell & Weinhold, 1989).

Changes in Income Level

Changes in income level were consistantly rated by those responding to the questionnaire as the most critical issue. It was the single most stressful event and was alluded to during discussion of the other issues in the study more than any other issue. One respondent aptly summed it up by stating that you need to "plan on spending lots more time working with lots less money to work with." Similar prevailing themes of encountering the most stress when one realized all he/she was giving up financially, and risking or putting off having material things permeated respondents remarks. Not only is this at issue with the individual but is is heightened in regards to the family system. Respondents agreed the spouse must similarly be willing to give up and sacrifice monitarily in the initial stages. There is stress not only in the commitment of resources but

in the lack of security of a regular paycheck which was one source of security many respondents sacrificed. Equal commitment on the part of the entire family support system seemed essential to the resolution of the stress encountered with this change in income issue.

Long Hours

A second critical stressful issue identified by the respondents was that of the long hours associated with small businesses. The comment "Be ready to marry your business" emphasized the magnitude of the time commitment involved in small business operation. Stress seemed to center on an inability to differentiate work and family and having insufficient time to allocate to both areas. The inability to do a satisfactory level of performance at work and attend to family was additionally stressful. The initial stages of the business venture seemed to demand the longest hours. During this time there was more need for family support yet paradoxically less time to spend with the family which would further heighten stress. The respondents also concluded that a basic understanding by the family support system is needed in the reallocation of time particularly in the initial stage of small business operation.

Stress of Bringing Work Home

The fusion of work and family time was a third critical issue identified as a stressor. As previously mentioned the long hours can be stressful, so can the inability of the individual to separate job and family when he/she is home. The same unrelenting drive that is evidenced by statements from the respondents like you must have "no doubt and willing to do and give all you've got to have it" which facilitated success in business breed stress at home. The long hours restrict the quantity of time spent with the family; however, the inability to separate work and home diminished the quality of the time spent with family. This fusion process often occurs at the height of stress at work and cuts the individual off from the family support he/she desperately needs. Some respondents seemed to have resolved this situation as evidenced in one remark that you need to "leave the office at work."

Increases In Communication Problems

Although "increases in communication problems" was rated as a third critical issue (tied with bringing work home) the importance of communication may be underrated. If the open ended questions are

tallied there are more comments on communication than the other three issues the respondents rated as more stressful. "Keep open communications so they (the family) know what you are doing and feel a part of your life" is representative of the concern the respondents expressed pertaining to the vital need for communication with spouse and family.

Family Support

The factors of support of the family support systems were consistent regardless of the sex of the individual going into small business. Those responding indicated positive support from family systems (spouses, parents, children). Only two respondents indicated no spousal support (one male, one female). The majority of the respondents (28) indicated they would make no change in their families if they could do it all over again while three would have postponed marriage and one postponed children.

Specific factors of support are outlined below:

	Spouse	Children	Parents	Siblings
1. Provided financial	8	3	4	5
2. Time (worked with business)	12	10	4	6
3. Emotional support	22	18	15	12
4. No support	2	4	5	11
5. Not applicable	11	15	11	10

The results indicate the most common factor of support given by the entire family system was emotional support. This was substantiated in comments written in open ended format where the need for family emotional support was cited several times. Counselors were also viewed as a viable resource by this population, and were used as often as a friend and almost as often as a family member to resolve a family crisis.

Summary

The implications for counseling skills and information dissemination is clear. The study has highlighted a need to modify some of the basic (Fenell & Weinhold, 1989) marriage and family counseling strategies to work effectively with this population.

Special consideration and focus need to be directed towards time based skills. Identified as a prime stressor in the form of working long hours and fusion of work and home, utilizing time becomes essential to the individual and his/her family. Additionally, a common support factor for most spouses and many children of the small business owner/manager includes time they allocated to the business. Because of this involvement the entire family may have at issue both working long hours and fusion of work and home. Arranging priorities (listing), time management, the definition of quality time, delegation of responsibility and leisure activity skills are all time based skills of use to this population. Practical solutions on how to manage the small business and a family need further development.

Communication, another critical concern for the family system and the individual, needs to be emphasized by the counselor. Target skills for this population need to address family issues because the spouse, children, parents and sibling provide extensive emotional support as indicated by the questionnaire. A family systems approach designed to address the specific communication concerns of the entire family system seems a logical starting point.

Further study of how current approaches in communication skills, time management and family counseling could be modified to assist this population is warranted. Likewise, a comprehensive assessment is needed to identify additional concerns of the individual in small business. Further studies would also do well to incorporate more individuals who have not succeeded in small business to ascertain if the treatments suggested would benefit them.

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PROFESSIONAL DISILLUSIONMENT: CRISIS OR CATALYST

Kay A. Miller
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Career choice is one of the most important decisions in a person's life, and it merits careful consideration. These choices often determine where we live, who we marry, and the style of life of our family. These decisions can have an impact on one's health, financial status, security, and autonomy. Once the choice is made, education and/or training requires a commitment of time, money, and family sacrifice. Anger and guilt weigh heavily upon the individuals who find themselves dissatisfied or disillusioned with the end result of their choices.

Changing one's job is not an easy or popular decision to make. Our society values loyalty to employers and the security that remaining in place allows. Quitting is frowned upon even when the reasons are valid and all the alternatives have been considered. Asking for a change in job description to have less responsibility is sometimes looked upon as an admission of weakness or failure.

Saltzman (1989) alludes to a growing rebellion in the corporate world with some employees deciding to get off the status treadmill and opt instead for positions which allow them to exercise greater control over their personal lives. People who find that success in their chosen occupation may alienate them from their families are questioning whether the benefits are worth the price. More and more

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people are deciding to stay with the same company or institution, but are choosing positions with a lower profile. They sometimes refuse promotions preferring to stay where they are rather than climbing to positions requiring greater sacrifices.

Early studies of voluntary career changers indicated that such persons were less stable than non changers; while recent research indicates no significant differences in the area of mental health (Herr & Cramer, 1988). Several theorists describe career change as a normal developmental function brought about by such factors as recognizing contrasts between early goals and current outcomes (Brim, 1976), inability to influence work environment (Lorton & Lorton, 1984), changing interests or needs (Isaacson, 1986), and need for greater independence or challenge (Zunker, 1986).

Clopton (1973) described three major classes of career changers: (a) those who are reacting to an occurrence that requires a change in personal goals, (b) those who gradually ease into new occupations without negative feelings toward the earlier positions, and (c) those who are disillusioned with their positions.

Michelozzi (1988) defines disillusionment as "seeing more clearly" (p. 45). The situation brought about by changing perspectives regarding one's job may be viewed as a crisis by some or it can become a catalyst for positive growth and change. The fact that the changing perspectives come in midlife is not hard to understand. The period between thirty and fifty is recognized as a time for reconsideration of one's values and priorities. It is also the time when professional people attain high levels of success in their work. For some people it is a time of discovery in which they realize that the success they have achieved is incongruent with their values or early expectations.

Demographic Career Study

Career counseling implications were found in a study designed to demographically define the parameters of the population enrolled in the alternate teacher certification program of a southern regional university (Cooper-Shoup & Miller, in press). All had earned previous baccalaureate degrees, were enrolled at least part time, and voluntarily participated in the testing and counseling provided.

Counseling sessions were conducted by a faculty member in the counselor education program and by a graduate assistant under the

supervision of the faculty member. The students were given feedback regarding the results of an interest inventory and a personality test. The content of those counseling sessions proved to be invaluable in recognizing which transition factors were involved in individual cases.

Findings

One hundred and fifty-six people were admitted to the program and complete data is available for 52. Previous degree areas were as follows: business - 7; fine arts - 2; science and mathematics - 13; social science - 15; health - 2; English - 13. It is helpful to note some of the comments given in answer to questions on the data sheets which indicate signs of disillusionment with the original career choice.

Career Disillusionment

A former social worker responded that she had abandoned her career because the work hours did not coincide with her children's schedules. Several who had majored in psychology, English, or fine arts found they had realistic expectations about job availability in their fields. Others found that their positions lacked the permanence or benefits that they had expected. Some were totally disillusioned because they found their work frustrating and unrewarding. A business major stated that he was not cut out for the business world, and he hoped that teaching would offer him the opportunity to do some good. Seeing their situations more clearly, they recognized that they had a choice of remaining in the circumstances or taking action.

Changing Goals

For many, the occurrence requiring a change in personal goals was the economic recession which devastated state and regional employment. They had already determined that moving to another part of the country was out of the question. Their counseling needs were focused on determining the appropriate levels and areas of certification to be sought. They also had to work through feelings of resentment regarding the circumstances requiring change.

The persons who fell into the disillusioned category provided the greatest challenge. Several had majored in subjects requiring graduate study. They did not know that a baccalaureate degree was insufficient to get a position nor had they sought out that

information through counseling services or career placement services.

Poor Advisement

Others reported that they felt betrayed by the instructors in their major programs. They had developed areas of expertise and felt relatively comfortable with their chosen occupations until they found employment in those areas. The job descriptions and employer demands did not match their expectations. The disappointment increased over time until they felt that some action must be taken. The anger was diffused over those who had encouraged them to pursue studies in nonmarketable disciplines, as well as to the employers who they felt had misled them.

Bureaucratic Process

Some of the business majors believed that their eventual work would afford them contact with people in positive ways. The reality of the corporate bureaucracies left them embittered and distrustful. They remembered reading about opportunities for people with business degrees and had been influenced by the beginning salary levels. They could not remember taking career interest or aptitude tests in high school or college to assist them with career planning.

Family

Some reported that they did not like themselves because of the work they did. Through further exploration, the reasons behind such feelings became clearer. Separation from families was one of the most difficult factors to handle. Positions in sales, transportation, and entertainment often require travel away from home. If one believes in family togetherness, it is difficult to balance the time away with quality time involving spouses and children. Marital and family issues were problems for some of these people. Several had divorced.

Common Concern

An obvious factor that stands out about all the counseling sessions is that not one person involved in the study had received any career counseling! Most did know if counseling services had been available in their high schools or colleges.

Effects of Disillusionment

Stress related to the workplace can impact on health, family integrity, and self esteem. All of us have worked with clients suffering from physical illnesses exacerbated by ineffective means of coping with stress. The people involved in this study were no exceptions. Several reported that they had or were dealing with stress related problems such as headaches, muscle pain, hypertension, and ulcers. There is no way to calculate the hidden health damage some of these people may endure, but increasingly medical authorities credit the stress factor as a leading cause or contributor of serious disease (Borysenko, 1987; Pelletier, 1977). One of the students involved in the study suffered a cerebral hemorrhage about half way through the fall semester. She is in her mid-thirties.

Counseling Interventions

What can counseling professionals do about this situation? The task is two fold: (a) to increase the availability and visibility of counseling services to prevent people from making uninformed career decisions, and (b) to provide sensitive, comprehensive counseling services capable of dealing with multidimensional problems related to career choice and/or transition.

Counselors working in school situations must do a better job of informing their constituencies of services offered. The back to basics movement in public education has definitely made it more difficult for counselors to get time with students at the secondary level. An assertive approach must be assumed in advocating the counselor's role in assisting young people with the career decision making process. Focusing on group approaches with a systematic program of infusion throughout the curriculum is a logical place to start. Several states have established guidance curricula outlining the manner in which this can be accomplished.

Counseling centers located in colleges must identify the best possible means of informing students of their existence and of the services offered. Informing faculty and staff of these services can be helpful in getting the word around. Encourage faculty to make referrals.

When counseling clients with career choice concerns, professionals should never assume that sufficient information has been gathered or that the information is from appropriate sources.

Relatives, friends, and neighbors can be helpful, but may have their own agendas. Maintain current resources in your office or agency to allow adequate investigation. Both state and national agencies offer such materials at little or no cost.

Those who feel career counseling involves matching jobs with people or vice versa fail to recognize the myriad of personal, physical, or family problems that can actually be caused by stress in the workplace. Stress, anger, resentment, and depression are but a few of the underlying feelings that are mentioned by disillusioned workers.

Specific Strategies

Suggested strategies for assisting clients with these issues are the following:

1. Accept that life is a series of stressful events requiring adaptation. Assist the client in understanding that these events need not be considered crises; rather they are catalysts providing opportunities for growth and change.

2. Encourage expression of hostile feelings through role play, empty chair, psychodrama, or letter writing as a means of ventilating and letting go of the past. Help them channel their energies toward activities which will validate their sense of worth.

3. Search for options which may allow them to remain in their current positions. Are there actions they can take to improve work environment?

4. Are there changes that can be made in other areas of their lives which would alleviate strain? Some people find fulfillment through volunteer activities, hobbies, study, and exercise. Can family or individual obligations be shared by others? In other words, will career change be necessary?

5. Use appropriate assessment materials to identify career interests, aptitudes, and values. Explore what other factors will affect the decision. Assist the client in seeking information about opportunities consistent with test results and limitations determined by client's goals and/or restrictions.

6. If further education or training is necessary, what will the costs be in time, money, family or personal sacrifice? It is effective for the client to construct a chart comparing the options. It is easier to focus on written, specific data than vague feelings.

7. Include relaxation exercises in every session. Expose the clients to information regarding the need for balance in life such as rest, nutrition, and physical activity. Remind them that the only thing we can truly control in our lives is the attitude toward our circumstances.

8. Establish a plan of action to continue through the education or training phase. Discuss the importance of beginning the job search before the completion of training. Work up new resumes. Ask the client to establish a packet including sample cover letters and reference contacts. Encourage the client to seek further assistance regarding preparation for interviews when they begin the actual application process.

Conclusion

Career counselors need to be aware that numerous factors may contribute to an individual's request for assistance in making career changes. The primary consideration is to define the factors before proceeding with job search strategies. Our ultimate responsibility is to empower the individual to effectively cope with the challenges life offers. Professional disillusionment need not lead to career change in every instance; but when it does, we need to provide the encouragement that will allow the client to place it in a positive perspective.

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ADULT SURVIVORS OF CHILD SEXUAL ABUSE: RECOGNIZING THE EFFECTS AND DEVELOPING A CREATIVE PLAN FOR TREATMENT

Patrice Moulton
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Recently more research interest and media attention has been generated around the issues faced by adults who were victims of sexual molestation as children. Child sexual assault is defined as any manual, oral or genital sexual contact or other explicit sexual behavior that an adult imposes on a child who is unable to alter or understand the adult's behavior because of his or her lack of power in the situation (Butler, 1985). This type of sexual experience is considered nonconsensual because the child has not developed a true understanding of sex or personal sexuality. Thus, the child does not have the skills needed to consciously choose to engage in a sexual relationship with an adult, especially an adult in a powerful position (e.g., parent, relative, teacher, baby sitter or family friend).

As research on child sexual abuse develops and expands, mental health professionals are beginning to understand the preponderance of the problem. Briere and Runtz (1987) found that approximately 44 percent of all female clients who presented themselves to a mental health crisis service reported a history of sexual victimization as children. Additionally, women who had experienced sexual abuse as children were twice as likely to have mental health problems as opposed to women who were not abused. In a study completed in Great Britain, Baker and Duncan (1985) reported that 12 percent of the females and eight percent of the males interviewed reported being sexually abused before the age of 16. Another study was completed in five cities across the United States (Cameron, Coburn, Larson, Proctor, Furde & Cameron, 1986).

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They determined that 16 percent of the people interviewed had sexual relations with an adult while under the age of 16. Nine percent of the males and seven percent of the females reported sexual contact with an adult before the age of 13. About one percent of the females reported sexual experiences with their fathers, and one percent reported sexual experiences with stepfathers. Approximately, one percent of elementary and three percent of secondary school students interviewed claimed sexual advances were initiated by teachers, and it was reported that one-third of these advances resulted in actual sexual contact (Cameron et al., 1986).

The lasting effects for adults who experience child sexual abuse are numerous. Often, the symptomatic behavior is offered to the counselor as the presenting problem or problems. Some common presenting issues that could suggest that an adult was sexually abused as a child are: depression, marriage and intimacy problems, sexual dysfunction, substance abuse, low-self esteem, and abusive or violent behavior. Suicide ideation is also a strong indicator of childhood sexual abuse. Former victims of sexual abuse are much more likely to have attempted suicide than were non-victimized clients (Briere & Runte, 1986). Also abused clients are more likely to report suicide ideation on intake. Thus, it is important that mental health professionals question all adult clients about childhood sexual experiences in the initial screening or early in the counseling relationship. Addressing the issue as "childhood sexual experiences" as opposed to child sexual abuse will probably seem less threatening to the client, thus producing more helpful intake information. Through developing rationalities and survival skills, some adults who were molested as children do not see the early sexual experiences as abuse.

When working with an adult survivor of child sexual abuse, the counselor must help the client decide which type of therapy (e.g., group, individual or both) will most meet the client's needs. Whatever method of treatment is selected several emotional issues need to be addressed and several skills need to be developed. These emotional issues and skills should be discussed with the client and included in the treatment plan. Issues common to nearly all adults who are survivors of child abuse are (a) remembering the abuse, (b) recognizing feelings associated with the abuse, (c) anger, (d) nurturing the child within, and (e) finding resolutions. The remainder of this article will focus on these issues. They will be discussed briefly and treatment techniques will be suggested.

Remembering

The issue of remembering is very frustrating to most survivors, and its role in the healing process is controversial. Bass & Davis (1988) state that it is a very natural desire to want "proof" of abuse within the memory system. Unfortunately, most survivors feel that their memories control them as their sexual abuse experience(s) is explored. The unconscious does not work on a timetable at will. Memories take on many different forms. They may be very specific and clear with details. They may be only fragments linked to uncomfortableness, or they may be waves of crashing emotional pain. For some survivors, only one small past relationship may exist or a feeling with no active memory attached to it may occur.

There are several possible reasons for memory lapse. First, if the abuse occurred when the survivor was preverbal or only beginning to learn to vocalize, the victim had no way of making sense of what was happening (Babies don't know the difference between touching a breast, penis, or thigh). Young children are aware of sensations but do not understand the concept of sexual abuse. Second, the time lapse between the event and the recollection makes it difficult for many to recall details. Turning long-term memory into short-term memory to use it as working knowledge is a difficult task. Third, if the actual abuse was what could be called adult/child boundaries (lewd looks, spoken vulgarity and advances, etc.), such abuse is often much subtler and harder to remember. Finally, victims have developed an emotional defense system that protects them from pain, shame, guilt, fear and a variety of other emotions attached to the abuse.

Through the authors' work with survivors of sexual abuse, the following strategies seem to loosen the grip of long-term memory and defense systems and enable clients to recall some of the information pertinent to recovery.

My Story

Clients are asked to make a journal entry of their counseling experience. Journal entries are to be as factual and detailed as possible, and clients share their entries with the therapist or group members. Through the process of writing, many survivors are cueing further long-term memory recall. The process of verbalizing can validate the facts and feelings, as well as prompt further insight.

Regression

With the help of their therapist, clients are returned to their childhood through the use of guided imagery. Relaxation techniques are used to help clients relax and focus on the time when the abuse occurred. The therapist then guides the client through an exploration of significant family, friends, feelings, locations and actual abusive experience, if the recollection becomes available. Use of guided sensory experiences (e.g., tell me what you see, including colors and details, what you hear, tactile memory, smell and taste) appears to uncover details of the abuse.

Art Aide

This technique enhances regression.

Following regression, the client is asked to draw the location of their memory and to color their picture accurately. This enhances the memory process by linking further detailed memories associated with various objects or focal points related to the abuse.

Feelings

Cooney (1987) listed the emotional effects of sexual abuse to include guilt, fear, low self-esteem, confusion, depression, anger, lack of trust and helplessness. She believes that research indicates that most victims of sexual abuse experience many emotional effects, but some of the effects may not appear until adulthood. These issues often are identified in clients as secondary to crisis, involvement in a dysfunctional system or dysfunctional patterns. Whitfield (1987) explained that people who grow up in troubled or dysfunctional families don't tend to get their needs met. Not getting one's needs met hurts. Because the parents and other members of dysfunctional families are themselves unable to listen, the abused child needs to be supported, nurtured, accepted and respected. They often are alone with no one to share their feelings. The emotional pain is so intense that the abused child defends against it by various unhealthy ego defenses, thus suppressing the feelings, away from awareness. Doing so allows survival, although at a price. Victims can become progressively numb, out of touch, false and co-dependent.

Thus, the adult molested as a child does not grow mentally, emotionally, and spiritually. Not only do they tend to feel stifled

and unalive, but they also often feel frustrated and confused. They are in a victim stance.

As the intense painful feelings become overwhelming to children with no emotional support for an outlet, they internalize. When the emotional pain becomes unbearable, they detach from it by finding a "numb" place to survive. This "numb" place is in the form of either denial or an awareness that the feelings are present, but not an acknowledgement in the form of a label or verbal expression. This pattern follows survivors into adulthood. Survivors possess a very limited intense spectrum of feelings. They also find themselves incapable of identifying and/or expressing feelings appropriately.

Techniques found to be useful with these adults include:

1. Feelings Journal: Clients keep a feelings journal to practice identifying and expressing feelings. The journal provides a safe practice ground. After approximately a 4-week period, the client reviews the journal and makes observations of patterns to his/her primary therapist.

2. Group Feed Chain: By using this technique in a group setting, clients are taught to express feelings appropriately. We begin by reviewing the rules of feedback:
Name:_____
I Feel _____
because _____
and what I need from you is _____.
The group chooses a feeling to practice. The leader directs the group by asking each member to place his/her right hand on the right shoulder of another group member who has elicited the chosen feeling through words or action. Each member then verbally practices giving feedback while maintaining physical and eye contact.

The group leader must help the group practice a variety of feelings. Anger is one of the most difficult for survivors to practice giving and receiving appropriate feedback.

3. Anonymous Feelings: The group is given one unfinished sentence at a time by the group leader. Each member is asked to write on paper his/her feeling.

ex. When I think of my childhood, I feel_____.
When I think of my molester, I feel_____.
When I think of myself as an adult woman I feel_____.

The papers are folded and placed randomly in the center of the group. Each member is then asked to choose a piece of paper, read it aloud and to verbalize as if the feeling were his/her own.

This technique instills unity and reciprocal understanding in a group by helping members realize that they are not so "different" in their feelings.

Anger

The feeling of anger is being discussed independently, because, of all the emotions a survivor may experience, anger is the most frightening and the most healing. Anger is not an emotion that is encouraged in our society. It is certainly not an emotion that children are encouraged to express, especially when it is directed at an adult. Many adults who were molested as children were never allowed to be angry about the abuse. Often, an adult who is taking the first steps toward healing may experience her first opportunity to feel anger about the childhood abuse. Without validation and permission for angry feelings, she may become overwhelmed with guilt because of the angry feelings and her inability to "forgive and forget." The client must understand that anger is a normal response to being hurt or wronged. The anger is not something that should be labeled as good or bad; it is simply a normal emotional experience (Engel, 1989).

A therapist helps a survivor throughtout the healing process by teaching her to release and experience her anger in a constructive way. Many of the techniques mentioned in the previous section are helpful in getting the client to release anger. Other useful techniques are guided imagery and visualizations. Writing exercises, in the form of letters (mailed or un-mailed) or journals are usually very beneficial. Brandon (1985) offers many structured writing exercises through the use of sentence completions. Physical releases, such as hitting, throwing, kicking, screaming and yelling,

if done in a safe environment, are healthy and healing releases for anger.

Child Within

Whitfield (1987) explains that the "Child within" refers to that part of us which is ultimately alive, energetic, creative and fulfilled; it is our "Real Self" -- who we truly are.

With our parents' unknowing help and society's assistance, most of us deny our Inner Child. When this "Child Within" is not nurtured or allowed freedom of expression, a false or co-dependent self emerges. We begin to live our lives from a victim stance, and experience difficulties in resolving emotional business which leads to chronic anxiety, fear, confusion, emptiness and unhappiness.

The concept of the "Child Within" is difficult for many survivors to relate to because of their intertwined issue with childhood abuse. Most survivors perceive that child to to be very small, weak, helpless, needy and vulnerable; all of which are extremely threatening. Therefore, if the child is not completely ignored, it is thought of in terms of blame, shame, hate or anger. Survivors who don't acknowledge the child, lose the positive, along with what they view as negative, including the softness, trust, curiosity and playfulness. Acknowledging and taking care of this child lets survivors take care of themselves. Forgiving the child is an essential part of healing.

Techniques to help clients acknowledge the "Child Within" follow:

1. Childhood Imagery: This technique is to be used cautiously with sensitive, chronic shock clients. In this technique, clients are asked to close their eyes and the therapist relaxes them. The client then completes mental tasks in the following order: (a) "Think of yourself as a child." (b) "Allow an image or symbol to come to mind of your child within." (c) "Place your image in a glass room and observe." (d) "If you can get past fear or anxiousness and feel the need to understand or care for this child, then open the door and go inside." (e) "Ask your child what it wants for you and what it wants from you and allow a response." (f) "Ask your child how it feels about you." (g) "Allow your child to respond." (h) "If possible, comfort your child by holding it, a hug or some verbal

closure." (i) "Tell the child you acknowledge its presence now, and that you will remain aware and work to allow yourself permission to show your 'Child Within'." (j) "Leave the room and when you're ready, open your eyes."

At this point, the therapist spends time processing the imagery with the client, and discusses ways to allow the child to flourish. This technique may have to be done over several sessions, gradually progressing through each task.

2. Being Accountable: This technique works well following imagery to supply options for the client. The client is asked to list as many childhood qualities as possible. Some of the common ones include being playful, curious, mischievious, silly, vulnerable, soft, trusting, etc. The client is then asked what role these qualities play in his/her life at the time. Many times, clients have difficulty identifying active childhood qualities. The client is then given the assignment of becoming actively accountable to practice activities that may enhance the qualities desired. Examples may include reading childhood stories, developing "play" time, allowing laughter and silliness when appropriate or purchasing a stuffed animal.

3. Letter and Response: This technique is used for clients who are evidencing strong signs of defensiveness against the child within. These clients are asked to write a letter to their child expressing their fears and frustrations. The second task involved in this technique is to have the client respond to the letter from the child's perspective by writing a response and using their less dominant hand to write.

This technique loosens feelings surrounding the child, memory process and also enables the client to gain some empathy or understanding for the child within. This may open paths for further exploration

Resolution

The final step in healing is reaching a point of acceptance and integration. Resolution is not necessarily an issue to be faced; it is

more of a point to be reached. It is an acceptance of the knowledge that the trauma experienced is a part of the sexually abused survivor's history, but that it does not have to dominate every facet of her life. Resolution comes with the realization that being a survivor of sexual abuse is only one part of a person who has many other pieces of personal history, interests, achievements, goals, and dreams. Resolution is a step that does not usually come without hard work and pain. Many survivors claim to reach this stage before they actually do. This often occurs when the pain of healing becomes very intense, and it becomes too difficult to continue the process. Bass and Davis (1988) described a true integration experience by stating that a survivor comes to realize that "there is no such thing as absolute healing. You never erase your history. The abuse happened. It affected you in profound ways. That will never change. But you can reach a place of resolution" (p. 167).

The "integrating experience" is a time for incorporating the survivor into the whole person. It is a time for acknowledging and validating the hard work, progress, and changes made. Finally, it is a time for the client to terminate the therapeutic relationship and move on to develop and concentrate on other areas of her life.

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YOUNG ADULTS AND AIDS: IMPLICATIONS FOR INFECTED WOMEN

Bernadette Mathews
Lee Rigby Robinson

> "HIV infection is not only the most significant health problem of the twentieth century, but it is also one of the most significant social issues of our time. HIV infection is changing our world and will continue to do so for decades". (Miramonties 1988, p. 263)

Background

The U.S. Public Health Service estimates that between 1 million & 1.5 million Americans are infected with HIV - the AIDS virus (Windom, 1989). Most will eventually develop AIDS, although the virus may lay dormant in body tissue for years (Curtis, Crummey, Baker, Foster, & Wilkins, 1989). As of July 1, 1987, Acquired Immune Deficiency Syndrome became the leading cause of death for women ages 25-34 (Curtis et al., 1989).

The majority of women who become infected do so by having unprotected sex with IV drug users or sharing needles themselves. Other women are exposed via sexual contact with a high risk partner. Most of these women are of child bearing age. The majority of new AIDS diagnoses are in intravenous drug users, their sexual partners and infants born to these couples (Rogers & Ron, 1988). Whereas education in the gay community has been highly successful, attempts to alter the sexual and usage patterns of drug using individuals are much more difficult. The reasons for this will be discussed later in this article.

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Currently, only approximately 1% of new AIDS diagnoses are found in gay males. More than 80% of these new patients are black or Hispanic and almost all are poor (Roger & Ron, 1988). Fifty-three percent of AIDS cases among children under 13 years old in the U.S. have occurred among blacks (Curtis et al, 1989). Specific problems of minority communities: poverty, unemployment, poor general health, inadequate access to proper health care, lack of health insurance and educational disadvantages, as well as higher incidence of IV drug use, have led to these disproportionate percentages.

However, the poor are not the only ones at risk. There are growing numbers of well-documented cases of AIDS in which the only obvious route of infection was heterosexual, vaginal intercourse. Almost all AIDS experts have concluded that the virus can be transmitted by vaginal intercourse. "There is absolutely no question that transmission from male to female occurs in vaginal intercourse" (Meyers, Coye, & Joseph, 1988, p.7). Female to male transmission can also occur, although HIV is passed less efficiently that way. "Heterosexual transmission is inefficient--but it works--and everyone should factor that into their decisions about life-styles, precautions, and sexual partners. The only method currently available to curtail the (AIDS) epidemic is to avoid all activities that spread the virus--including unprotected vaginal intercourse" (p.9).

Seropositivity and Women

According to Kloser (1988) who has worked with over 400 HIV infected women ranging in age from 18 to 77, women who develop AIDS die more quickly than men. Perhaps these women ignore the symptoms, are not aware of the symptoms that may signal the HIV infection, or are not diagnosed until late in the progression of the disease. Dr. Kloser recommends using triple protection when having sex with "an unknown or high risk partner. This means a diaphram, a condom, and a spermicide with nonoxynol-9" (p. 4).

IV Drug Use, Women and AIDS

According to Staver (1988) in New York City perhaps 50 to 80 percent of the approximate 50,000 women who are IV drug users carry the HIV virus. In addition, the estimated 120,000 New York City women who are the sex partners of male IV drug abusers also are at risk of becoming infected, since an estimated 50 to 80 percent of the men are seropositive. These women may be even more

susceptible, because most of these women are probably unaware of the danger they face.

Persuading women of the peril they risk will be difficult, according to Nobles (1988). To date, few culturally sensitive educational materials have been developed for these women compared to numerous explicit materials for gay men. Furthermore, while gay men have organized to support one another, these women may feel little connection to one another. Consequently, it is less probable that they will create the sense of community support evidenced by gay men. At the moment, few women are taking precautions to prevent infection. Those who do perceive their own risk will probably receive little cooperation from their partners (Nobles, 1988).

Suki Ports (1988), former director of the Minority Task Force on AIDS, said women with AIDS have far fewer resources than the gay men who were the epidemic's earliest casualties. These women are often unemployed and therefore have no health insurance. Many have a long history of poor health before their diagnosis.

Pregnancy and Seropositivity

Women who become pregnant may be unaware that they have contracted the virus. Some of the early symptoms of infections such as fatigue, nausea, and weight loss may be attributed to pregnancy and thereby mask the presence of the HIV virus. Additionally, pregnancy suppresses the immune system, providing an avenue for infections such as herpes simplex, toxoplasmosis, pneumoyitis carinii pneumonia and vaginal candidiasis (Minkoff, 1987). And although the evidence is scarce, the altered immune status of the pregnant woman may accelerate progression of the virus.

Pregnant addicted women are a difficult population to provide consistent services for. In the early 1970's when methadone maintenance programs were popular, women were more visible. But as the programs vanished, so did the women. Such women often "distrust all the institutions who can identify the illegality of their lifestyles" (Mitchell, 1988, p. 2). Counseling minority women not to become pregnant often means that the patient "will never come back again," said Dr. Mitchell (p. 2).

Barbara Gibson (1988), director of AIDS education for New York City's Addiction Research and Treatment Center, underscores

the difficulties in educating these women to insist that their men wear condoms. Many are fearful that a condom-or-no-sex ultimatum will cost them their partner. Many women, "have been socialized to feel that if they don't have a man in their life, they have no life" (p.4).

In the two New York City hospitals where most pregnant HIV-infected women are cared for, most choose not to terminate their pregnancy (Mitchell, 1988). "This doesn't surprise me. Having children is important to many of these women. For many, it's the first time they feel good about themselves and the first time they have an incentive to change their behavior in regard to taking drugs" (p. 3).

Challenges Faced In Counseling Seropositive Women

Most infected women belong to minority groups beset with macho values. These cultures frequently denounce and deny bisexual activity. Without help and support these women may find it impossible to confront their partners about past sexual history, using condoms, and sexual activities that should be avoided. Unless counselors take into account the cultural sensitivities of their particular patient, it is unlikely that these women will be receptive to attempting change.

Furthermore, seropositive women must determine whether to terminate or avoid pregnancy. Confronting their fears, concerns about religious and cultural consequences, and the reactions of family members, husbands, lovers, and others are all components of the decision making process. Counseling can play a significant role in providing support to these overburdened women.

Currently most education is aimed towards at-risk women. However, limiting public health education to this group would be ill-advised. All women need information about the transmission of the virus and should be supported in adopting a strong stand regarding sexual practices that will protect their health. According to Selwyn (1987): "Any intervention program must appreciate their situations. If you come in with a heavy-handed message, that is unacceptable for ethical and social reasons, and also won't have the desired effect" (p. 6).

Describing an attitude that would incline a woman to maintain and even pursue pregnancy despite the risk of AIDS, Selwyn (1987) comments that in many minority communities, women depend on

their men and their babies for both pleasure and self-esteem. According to Minkoff (1987), "reproductive and sexual relations are a very important part of their lives. It's not like they can say, I'm depressed so I'll go to Bloomingdales. If they have a child, they're respected and valued" (p. 2716).

Women, Children and Seropositivity

Children younger than eighteen months provide special challenges for HIV detection. Children are born with vestiges of their mother's immune system; if the mother is HIV positive the child will also test positive. However, the infant may later seroconvert and become negative once her/his own immune system develops. A positive HIV test in a child younger than eighteen months does not conclusively confirm infection.

A positive antibody test in a child signals a need for testing other family members. In some families all may be seropositive. A mother may discover that she carries the virus only when she learns that her child is infected. She may have known of her risk, or the diagnosis may come as a total surprise. A positive test result or AIDS diagnosis in a child may expose a partner's drug use (past or present), bisexuality, and infidelity -- issues that even without the threat of AIDS may destroy a family. Fears for one's own life, concerns that any other children may also harbor the infection, decisions regarding termination of pregnancy must all be addressed. A mother with HIV has a 50 percent chance of infecting her fetus (Thomas, 1984). "A parent's first question is usually 'will my child die?' Often, the next question is 'Who will die first'?" (Thomas, p. 642).

These uncertainties lead to fears about who will care for the baby if the mother becomes incapacitated. Many HIV positive babies who become sick will remain hospitalized throughout their brief lives. If the mother is also ill, they may be unable to care for their children. Some mothers are even hospitalized in a different facility than their children. Some mothers (still quite ill) leave the hospital because there is no one else to care for the children. There exists a grave shortage of foster homes for these children, many of whom are unwanted by their extended families. Many foster parents are unwilling to accept a baby whose mother has AIDS or who is herself seropositive.

Implications for Women and Children

For children, the signs and symptoms of AIDS include: failure to thrive, such recurrent bacterial infections as Otitis-media (inner ear infection); chronic intersitial pneumonitis, thrush, and lymphadenopthy (Bolard & Gaskill, 1984). Because protracted infections such as thrush and herpes interfere with eating, nutritional intake must be closely monitored. Weight loss, chronic diarrhea, shortness of breath, fatigue, and impaired growth are common. Neurological complications often result in cognitive impairment and regression in developmental milestones. Children may revert to earlier stages and stop feeding themselves, become incontinent if previously toilet trained, or stop walking and resume crawling (Rogers, 1985).

The incidence of AIDS in women is expected to rise dramatically (Chachkes, 1987). Beyond the myriad problems which beset all those with AIDS, women must cope with special complications arising from their roles as mothers. Two major issues are (a) decisions to be addressed regarding pregnancy, and (b) segregation from children during hospitalizations.

Should she terminate the pregnancy? If so, she may experience profound grief and loss. Should she maintain the pregnancy in hopes that she and her baby will be spared? The pregnancy will be a time of anxiety, uncertainty and guilt. If she fears abandonment by husband or family, she may struggle with these issues alone.

Infected women must address other matters as well: potential loss--either of her child or of her ability to watch her child grow up in the event of her own death; explaining the illness to the children and other family members; dealing with the inevitable trauma to the family system; attempting to prepare for an uncertain future. Social supports for these women are, in many cases, woefully inadequate.

For children with AIDS, separation from the mother is perhaps the greatest stressor. A child's developmental age determines his or her ability to understand what is happening. Because many pediatric AIDS cases involve children under six years, separation is more critical than an awareness of their impending death (Chachkes, 1987).

Catastrophic illness impacts all aspects of family life--individual roles, economics, as well as communicaiton among members. Initially, the family must strive to accept the diagnosis

and its many ramifications. Long-held secrets about drug use, homosexuality, and prostitution may have to be confronted. The fact that lovers, spouses and children have been put at risk as a result of these activities must also be acknowledged. Those women who remain asymptomatic while their children develop AIDS carry overwhelming guilt, pain and sorrow as they watch their babies deteriorate and eventually die.

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ADULTS RETURNING HOME: ISSUES AND INTERVENTIONS

Peter Emerson

The familiar phrase "Hey Mom I'm Home" uttered by Beaver Cleaver once elicited a favorable recognition reflex from Ward, June and millions of television viewers. Now that same phrase spoken by a rapidly increasing population of adults returning home to live facilitates a lump in the throat and a wince instead of a smile. Far from being just an isolated event, the number of young and middle-aged adults returning home to live with their parents is reaching epidemic proportions.

Conservative estimates by the U.S. Census Bureau (in Hayes, 1987) indicate that the population of young and middle-aged adults living at home with their parents has reached twenty-two million (p. 1). These estimates identify a substancial segment of the total population, yet one expert, Phyllis Jackson Stegall, asserts that twenty-two million is a gross underestimation of the true number of young and middle-aged adults living at home. In a recent telephone interview with Stegall (personal communication March 15, 1989), she disclosed that based on her current research the true number is at least fifty percent greater than the U.S. Census Bureau figures. According to Stegall, there are thirty three million young or middle-aged adults that are currently living or have lived at home during any census period. Rational for the tremendous discrepency between census figures and Stegall's stem from the transitory nature of this population. "Many of these individuals live at home for a period of a couple weeks, a few months or a year. Those living with parents for shorter periods of time are not accurately reflected in census data" (P.J. Stegall, personal communication March 15, 1989).

Due to the widespread nature of this developmental issue one

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would expect to find ample research on the subject. However, beyond Okimoto and Stegall's Boomerang Kids: How to Live with Adult Children Who Return Home no primary reference sources could be found. Current developmental texts also neglect to mention this population. Kaplan (1988) explores a variety of "lifestyle choices" for the young and middle-aged adult yet none include returning home to live. Even his detailed analysis of the "consequences of divorce" (p. 396) failed to mention returning home as an option. Indeed, the absence of research on adults returning home to live is indicative of the lack of investigative focus on the young and middle-aged adult populations in general.

The primary focus of this study is to establish basic data on the returning home phenomenon. Developmental issues faced by the young and middle-aged adult will be examined in light of casual factors that facilitate the return home. Profiles of the parent and adult child will be sketched out to discover if there are commonalities of experiences among the study group. Finally, suggestions for possible interventions and avenues for further research will be explored.

The Survey

The survey questions consisted of twenty open ended queries designed to identify specific developmental issues confronting the returning adults. Also of interest were correlative casual factors that facilitated the respondents move home instead of another option such as moving in with peers. From the survey it was also hoped to glean information needed to develop a profile of the parent and adult child in this situation. The survey was administered to a total of fourteen parents whose children had returned home to live. Six of the parents participating were single parents attributable to death or divorce. The balance (eight) were in traditional marital relationships. The adult children returning home consisted of ten single children and one married couple (one family had two adult children living at home).

Developmental Issues

Developmental literature stresses three specific issues, divorce, re-entry into school, and unemployment, as common experiences of a majority of young and middle-aged adults (Kaplan, 1988). The survey concurred with these findings discovering that divorce, re-entry into school or unemployment either as an individual issue or

in concert with each other were identified by all respondents as developmental issues with which they were confronted. Specific survey results identified re-entry into school to complete studies or for retraining as the most common reason for returning home. A total of seven respondents identified this as their primary reason for returning home. Four of the participants indicated re-entry into school was the only issue confronting them while two stated divorce had facilitated the return to school. Unemployment was a secondary issue for one respondent returning to school.

Divorce was cited as primary motivation for returning home by three adults. All three indicated they entertained thoughts of returning to school. Only one individual identified unemployment as an overriding influence on the return home and stated the other developmental issues were of no current concern.

Re-education, divorce and unemployment are developmental issues confronting millions of young and middle-aged individuals who do not return home (Kaplan, 1988). Selection of alternatives other than returning home raises further questions as to possible casual factors that would contribute to the decision to return home. The respondents did identify several casual factors consistent with results obtained on the other homogeneous populations (Hayes, 1988; Okitomoto & Stegall, 1987). The identified casual factors were financial hardship, low self esteem, lack of responsibility and a positive relationship with parents.

Financial hardship was the unanimous primary casual factor identified by all adults returning home. Eight individuals also cited feeling poorly about themselves as having affected their decision to move home. Not wanting to make a decision (not taking responsibiltiy) was mentioned by five individuals. "I can't make up my mind" and "I need time and space to think this out" were indicative of the lack of responsibility exhibited by the participants.

Financial hardship, low self esteem and lack of responsibility tended not to be independent. The three were intertwined and at points in the interview indistinguishable. An example of this was an answer to an open ended question of financial hardship. The respondent stated "Yes I can't make it on my own financially; I need my parents; I can't think what I'd do without mom and dad." The respondent commingled fiscal hardship and low self opinion while capitulating responsibility to parents.

Profile

Since little has been done to establish a pool of information on either the parent or returning adult, research to define some parameters is warranted. Similar and divergent characteristics for both groups were discoverd by the survey. Divergence was found in the ages of parents and adults returning home. Parents age at the onset of return ranged from thirty-nine to sixty-seven. The adults returning were anywhere from twenty to forty-five. Neither of these populations displayed any significant clustering at any age category as indicated in the chart below.

Parent	35-39	40-44	45-49	50-54	55-59	60-64	65-70
	2	2	3	3	1	1	2

Adult Returning	20-24	25-29	30-34	35-39	40-44	45-50
	2	2	3	2	2	1

Income levels of parents at the time of return were equally distributed within a range of between seventeen and eighty-five thousand dollars. The adults returning, however, experienced an extreme negative skew toward the low end of the salary scale. Six returning adults were earning less than ten thousand while three of the respondents had no income. Only two of the eleven earned twenty thousand or more and one of those made more than the parent with which they returned to live.

Similar characteristic feelings indicative of each group (parents and adults returning) were expressed by study participants. Parents who viewed the return as a negative experience shared common feelings with other parents having a like negative experience. The parents viewing the return as positive had similar common feelings with other parents sharing like perceptions. The returning adults too grouped in common experience according to how they viewed the return, either as a positive or negative experience.

Negative Return: Parents Anger

All of the parents indicated that when they first learned about their child's intention to return home it was upsetting. Being upset at the child's return is a common emotional reaction as Stegall summarizes, "They'll (the parents) take them back, but often not without feeling resentful and angry at having their own plans shattered" (in Hayes, 1988, p. 1). The anger was seldom manifest in

overt behavior in the interview. Instead indirect communications from the parent to the adult child and interviewer were common. Some parents used the interviewer as a conduit for conveying these passive aggressive messages to the adult child. Remarks such as "We never expected him to return home", "She came back just as we were enjoying ourselves", and "This has been an unexpected setback for us" in many ways exemplify the passive expressions of hostility encountered during the interviews. Such resentment is consistent with Okimoto and Stegall's (1988) results.

A second characteristic emotion experienced by parents viewing the return as negative was guilt. Only one parent identified in the group experiencing a negative return failed to mention guilt as a feeling they have experienced. Reasons for the guilt identified by the respondents centered on anger, and a sense of failure. Parents thought that they shouldn't feel angry with the returning adult which facilitated more guilt in a cycle that is similar to the experiences of individuals feeling anger toward the dead (Uroda, 1977), while at the same time feeling guilt about the anger. Most parents also believed that they had failed and verbally inquired "Where did I (we) go wrong." Indeed, other research verifies "Many parents see the return as a failure" (Hayes, 1988, p. 1, 9). The parents' sense of failure seemed to be associated with a belief that they had not taught their "child" how to cope sufficiently with life. Viewing the failure as their fault heightened the guilt experienced by the respondents.

Dependence

One of the married couples and all but one of the single parents shared a belief that their adult child (children) could not function without them. Stegall reported parents making statements like "my child needs me" (in Hayes, 1988, p. 9). This ideology was consistent with statements made by responding parents like, "Where else would he/she go", "Who can you turn to but family","We are always here", obtained in this study. This indicates a dependency issue among parents in this study concerning a need by the parents to be needed by the adult child. Beside such verbal expressions, consistent behaviors were displayed by the parents creating returning adult dependency on the parent. Often the parent would get things for the adult child, or clean up after him/her during the interview. Other verbalizations of doing "for them (the child) on a routine basis that they can do for themselves" (Walton, 1980, p. 6) further indicated an atmosphere of dependence on the parent, created by the parent. Such pampering consisted of picking up laundry at the

cleaners, running shopping errands and buying various supplies for the adult child.

Parent: Positive

There was much less guilt among the parents who viewed the return home positively. The initial resentment at having plans interrupted was short lived. "At first it was a problem but after a couple weeks it was back to normal" was typical of the statements made by these parents. Back to normal meant the parents felt the returning adult was responsible for himself/herself. One result was that the parent(s) functioned much as they had prior to the adult returning. "We don't let this interfere...if Bill wants to go with us it's fine if not it's fine too!" The parents in this situation viewed the returning adult as responsible and communicated openly with him/her. The parents in this group rarely did things for the adult he/she could do for himself/herself. If the parent did assist the adult child there was reciprocity by the adult child. This two - way give and take created no dependency in either direction.

Returning Adult: Negative

The returning adult was highly resentful toward the parent in the returns identified as negative. The leading reason cited for the resentment centered on being treated as a child again. Stegall "cautioned against trying to maintain a traditional parent-child relationship" (in Hayes, 1988, p. 9). Such relationship results facilitates resentment (Okimoto & Stegall , 1987) either in passive forms or directly. The passive forms indicated by the respondent included: leaving the cap off the toothpaste, leaving lights on, looking in the refrigerator for extended periods of time, not studying and procrastinating applying for work. Direct forms consisted of taking money from parents, arguing or yelling at parents and physically striking back.

Uncertainty was another common experience expressed by adults in this situation. They failed to construct time lines for goals. Often this included not knowing when they would or could move out on their own.

Failing to take responsibility for their situation or personal action was a final common experience. These adults blame circumstances beyond their control (ex-spouse, etc.) for their misfortunes in life. The failure to take responsibility often commingles with the parents trait of creating dependency forming a

complimentary "overprotective" family atmosphere (Dinkmeyer & Carlson, 1984).

Returning Adult: Positive

It seems trite to identify the characteristics of the positive return as the antithesis of the negative experience but it's accurate. The adult in the positive returning situation was far more appreciative. They seemed to feel like they were equals not subjects in their parents' home. Additionally they acted responsibly which was manifest by definite goals to leave the parents' home. They had a realistic time line and plans to rebuild their independence. They also contributed to the parents welfare by doing household tasks, paying rent or working at family businesses.

Interventions

The returning home experiences of the participants in this study imply two areas needing intervention. These two areas concern self confidence and taking responsibility for self, for both parents and returning adults experiencing a negative return home. Conversely parents and returning adults who exhibited self confidence and responsibility minimized the problems of the return and expressed having a positive experience.

Specific strategies would depend on the counselor and how he/she views self-esteem and responsibility. Dinkmeyer, McKay, Dinkmeyer, Dinkmeyer & McKay would suggest that responsibility is inseparable from self esteem "Keep in mind that self-confidence means being able to say 'I can do it myself'(1987, p. 37). Such an approach would seek to improve self esteem by teaching responsibility. Walton (1980) outlined several specific methods for teaching responsibility to teens which are easily modified for applications with returning adults. Essential is the principle that they become fiscally responsible for themselves. "The teen can experience more self sufficiency by entertaining part-time work" (Walton, 1980, p. 18) is easily modified for the returning adult. "Parent and child (returning adult) need to reach a business agreement concerning rent, which should, depending on the child's earnings, amount to a reasonable proportion of their income" (Hayes, 1988, p. 9). Other methods Walton covers are equally adaptable. They seem particularly relative since the study indicates these developmental issues that were not resolved while a teen at home the first time.

If viewed as separate issues the methods Walton (1980) offers would be taught for responsibility training and self esteem issues dealt with separately. Many alternatives are available to the counselor who chooses to work with self esteem as a separate issue. Simon (1978) offers a variety of self-esteem building methods for all developmental age levels.

Further Research

It is hoped that further research will expand the amount of data presented in this monograph. Larger samples are needed to obtain truly valid conclusions about this population. Such investigations should also strive to identify additional areas needing intervention. Testing of the suggested interventions in this monograph and those to be developed is also needed.

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INTIMACY FROM A LIFESPAN PERSPECTIVE

Carolyn Cavanaugh

Much has been written on the topic of intimacy and it has been studied from many different perspectives. Some of those perspectives underline trends of declining intimacy, tracing the decline to the democratic and industrial revolutions, with resulting urbanization, separated families, big institutions and government, mass media, technology, rapid pace and ever increasing numbers in everything. In human terms that has left people lonely and out-of-touch. A similar perspective looks at how people are forging new meaning in a variety of relationships to supplement the closer extended family of the past, how they are seeking out counseling and small group encounters, and even how the T.V. and Radio "talk shows" are on the rise, and noted this as a drive toward intimacy.

Some researchers have focused on the biological and sexual aspects of intimacy; some on its intellectual or emotional aspects (McAllister & Bergman 1983); some compare the personal or static aspects to the more relational and dynamic aspects (Cline, 1983); some have focused on depth and breadth of exchange (Joulard & Laskow 1958); others on interdependence and commitment (Kreilkcamp, 1984); and yet others on the self-disclosing aspects of intimacy (Waring & Cheluve, 1983).

This article borrows from several of these approaches to focus on intimacy as a relationship which is personal, private, and dynamic, with self-disclosure as its most important component. It is a psychological intimacy rooted in a reciprocal relationship with another person, and may be found in or out of marriage, with or without sexual relations, with friends or family, and throughout the life course.

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Thus defined, what can be said about intimacy? It is necessary; it must be developed and maintained; and it exists itself over the life cycle.

The Necessity of Intimacy

Research supports the idea that intimacy is necessary to human life, and indeed necessary for several aspects of our lives. Survival, mental health and happiness, and growth are three needs of which intimacy is a major component.

The Survival Component

Intimacy is adaptive for survival and historically had led people to bond together in groups in order to build shelter, provide food, give protection, and satisfy needs. Psychological intimacy is the "we" part of the "we-them" concept. Konrad Lorenz saw "them" part of this concept as a mechanism to deal with aggression and thus as a component of survival. But the "we" which he saw as "precursor of friendships and more intimate relationships" is also vital and no less a component of survival (Benton, 1974). Psychological intimacy is "an overlooked requirement for individual and collective survival, which is as essential to life as food, water and sleep. Without some degree of emotional intimacy we will kill each other" (Dahms, 1972).

In an age of street and family violence and nuclear war, it becomes clearer that to relate to someone close to us, or from another culture, in a personal, self-disclosing, and dynamic way, connects us to the "we" and may ultimately prevent us from "killing each other."

The Mental Health and Happiness Component

Besides physical survival, intimacy is necessary to mental health and happiness and is linked with them in many studies. There is a "strong correlation between intimacy and psychological well-being" (Traupmann, Eckels, & Hatfield, 1982). The same authors report a study that measured how women with confidants had (a) higher morale, (b) less psychosomatic symptoms, and (c) higher ability to cope with stress than those without confidants. Having close interpersonal ties has been linked to life satisfaction, sense of belonging and identity.

That intimate relationships help avoid pathology, as well as lead to positive mental health and happiness, is shown by a study of schizophrenia, which found that "young pre-schizophrenics are saved from becoming full-blown ones by the buffer of a close friend relationship" (Benton, 1974). Horowitz found that most people seek psychotherapy because there is "a failure to develop an intimate relationship (Waring & Cheluve, 1983). These are a few examples of the idea that when we experience psychological intimacy we feel better about ourselves and have greater life satisfaction.

The Growth Component

The third area where intimacy is necessary is growth, which in this sense is associated with self-actuaiization. People who are intimate experience greater growth because they come to know more about both themselves and others.

The non-intimate hide themselves and may not be able to perceive complex motivations and emotions in others. Both they and others may be ignorant of their needs and feelings (Derlega, Valerian, & Chaikin, 1975). People hesitate to be intimate for fear of conflict, but "conflict is a necessary condition of psychological growth" (Dahms, 1972). Maslow summarized the importance of intimacy for growth in his statement "The inability to be intimate and honest with at least a few other persons blocks self-growth and prevents the fulfillment of one's potential" (Derlega, Valerian, and Chaikin, 1975).

This section has demonstrated that for survival, growth, mental health, and happiness intimate relationships are needed and are something to be achieved. The ensuing question then is how does one achieve intimacy and keep it once achieved?

The Development and Maintenance of Intimacy

Along with the knowledge that intimacy is a necessity, intimacy is also developed and maintained throughout the life-span, and is largely a product of learning and effort. While the first step is simple contact and may not involve much effort, the later states of warmth, communication, commitment, and the forming of interdependent units require different skills.

The Development of Intimacy

The development of intimacy between two people is a gradual and time-consuming process. One begins with a range of acquaintances, usually within boundaries of social class and geography. There are first impressions and beginning contact, and then continued initiation. Slowly things emerge.

At some point the key is a move toward self-disclosure. Self-disclosure is seen most graphically as a "peeling away" process where after broader and deeper penetration a person's "true nature" is discovered and thus intimacy unfolds. (This is the social penetration of Altman & Taylor.) When we self-disclose, we express needs, emotions, thoughts, beliefs, attitudes, fantasies, and self-awareness (Waring & Cheluve, 1983). Self-disclosure is a more honest and less controlled way of relating and is based on trust and acceptance. "One consistent finding in research on self-disclosure is that disclosure by one person elicits self-disclosure from another person: a person's intimate" (Derlega & Chaikin, 1983).

To develop an intimate relationship, someone must risk first. If no intimate relationship develops between two people who are taking a risk, then the cause is usually that neither party is initiating an intimate exchange or the recipient of an intimate exchange is claming up (Darlega & Chaikin, 1975). Intimate communication is an effort to relate and to explain one's "central meaning and values to a reciprocally respected other who will comprehend and appreciate one's essential thoughts and feelings" (Shor & Sonville, 1978). As one tries to do this, gradual trust develops and more self-revelation, acceptance, support, and warmth develops. As the layers of distrust and reticence fade, intimacy occurs.

Maintenance of Intimacy

Once established, some important factors in maintaining an intimate relationship are: self-disclosure, trust, tolerance, acceptance of change, and careful expenditure of psychic energy. Self-disclosure is a key to both developing and maintaining intimate relationships, and it is important that self-disclosure be continuous. Also it must be appropriate and healthy and not indiscriminate. The intimate relationship is vulnerable and open, so trust must not be violated by either party if intimacy is to continue. Trust is crucial if one is to expose his/her humanity to another. And sharing requires tolerance by both intimates. The same characteristics that one tolerated in a

friend might be unacceptable or devalued when exhibited by a stranger.

Change is inevitable for individuals, and it requires work to keep in touch with one's intimates. McCall and Simmons said that "relationships must change with the change of its members in order to last" (Cline, 1983). One must accept the ebb and flow of closeness, and recognize that mutual sharing may not be equal for any one encounter; yet there is a balance and adjustment over time (Derlega & Chikin, 1975). This is the dynamic part of intimacy.

To maintain intimate relationships, attention must be given to expenditures of psychic energy, because emotional intimacy is a process that requires constant attention. "When time and energy are not expended entropy sets in and the relationship deteriorates" (Dahms, 1972). Yet some behaviorists say that each person has a "fund of intimacy" (Brenton, 1974). This fund may vary from person to person, yet there may be a limited amount to give for each person. This means that if our "fund of intimacy" is depleted in one relationship we may not have it to give in another. Thus when the intimacy level gets too high, people find ways to withdraw.

The development and maintenance of intimacy is a complex and difficult process, but something worth trying to achieve. To better understand the concept of intimacy, those aspects of intimacy that depend upon the biology and circumstance of the maturing and aging process will now be reviewed.

Intimacy Across the Life Cycle

At each developmental stage intimacy has different meanings and evidences itself in different ways. Its characteristics at each developmental epoch demonstrate why it is so important to take a lifespan perspective when considering intimacy.

Childhood

Although intimacy is usually considered a developmental task one attains in adulthood, its roots can be traced back before birth. People begin as part of others, mature biologically until the physical separation of birth, and only then undergo a process of psychological hatching or differentiation (Kreilkamp, 1984). As the process of growth moves in this direction, the experience of closeness becomes possible. Once others have been identified as separate, then children can begin reaching out to others. This is

usually accomplished by age two or three, and then the child continues through phases of contact involving parallel play, shared play, and relating to groups of children.

The norm for this period is that playmates model and teach about future relationships but do not serve as true intimate relationships. This is probably due to children having "not attained sufficient autonomy and differentiation for closeness to be a meaningful dimension of their experience" (Thomas, 1984).

Adolescence

Relationships, like everything else in adolescence, are marked by intensity and ups and downs. Youth are faced with fears, estrangement, and anxieties over dealing with changes and sexuality. They desperately need someone with whom to share these fears and exchange information, but parents are often unwilling or unable or undesirable confessors. The peer group fills the need because they share the same feelings and need.

It is important that adolescents have confidants and that there is mutual expressions of love and trust. "During the period of adolescence, peer groups may be most open and most subject to personal intimacy" (Bensman, 1979). Friends become a tremendous influence for behavior, and adolescents go to friends to consult on everything, to tell everything. Friends are also a source of conflict, but worse than all their trouble is to have no friends at this crucial time. In general, adolescent friendships serve as a vital step in self-learning and learning how to be intimate.

Young Adults

This epoch includes many categories, including married and single, collegiates and young workers. The intimacy patterns of each are somewhat different. The "college" or "job" separation after high school is a big factor, friends are chosen largely from those who grow in the same direction as we have.

Generally there is less intensity in relationships at this time, and friendships rise more out of security than the vulnerability they arose from in adolescence. This is a time of expansion, and friends are needed to test how we are doing in getting on with our lives. College friends may aid in intellectual growth and reaching potentialities. Also friends are there to ward off loneliness in lonely places.

Out-of-college singles have relatively unstable relations. There is pressure for new people, new relations, and there is constant turnover of peers and friends. People get married, move and if one is not constantly changing friends, he or she is alone. There is also a preference for one-to-one relations rather than the groupness of adolescence and college. The primary focus is usually finding a partner, so other intimate relationships take a back seat. Friends function to help judge or approve the "partner;" to share happiness if the true love is found; to serve as security blankets in dealing with the vulnerabilities of love; and in general to serve as sounding boards for growth (Benton, 1974).

Intimacies undergo re-sorting for young marrieds. Time and psychic energy become major factors. The focus on marriage and the partner is the new thrust and priorities must be set accordingly. Emotional demands of partner and family are paramount. "For most Americans marriage is the relationship in which the highest levels of disclosure are expected" (Darlega & Chikin, 1975). The idea of the spouse as the confidant or best friend or intimate is a strong one, because there is a "positive relationship between marital satisfaction and disclosure of feelings to one's spouse. Couples who reported disclosing higher proportion of feelings to each other had happier marriages" (Darlega & Chikin, 1975). Another study of couples from 18-50 showed self-disclosure as a major determinant of intimacy levels and accounted for half the variance in satisfied couples (Waring & Cheluve, 1983).

In marriage, however, people begin to realize that the partner cannot meet all their needs, so friends are still important to this life position. Even then, marriage styles dictate the friends chosen. In a large scale family-socializing study, (a) 27% of couples chose separate friends; (b) 31% chose couple-to-couple friends; and (c) 42% chose both. Couple-to-couple friends are more complicated relationships, due to the four distinct personalities involved, making flexibility and tolerance more important. The study also concluded that "the more we, as couples, have in common with other couples who are our friends, the less likely we are to get divorced" (Benton, 1974). Other studies have shown how outside friends both reduce and produce conflict. To a large extent, children have the same effect.

Young adulthood is usually a period of personal growth, partner - and family-centered intimacy, with friendship either serving these efforts or being peripheral.

Middle Age

Middle adulthood is usually considered a time of low intimacy. Time and task demands of job and family deter high levels of intimacy. Relationships are based on demonstrating that one has arrived and achieved and that one is a mature adult. This interferes with intimacy because there is an avoidance of sharing weakness, failure, and foibles. The private and intimate self are likely to be denied. "There is an implicit agreement to avoid probing, to avoid revealing one's self, and to avoid broadening and deepening the relationship" (Bensman, 1979). Communication problems are put off for pressures of job and children, thus decreasing marital intimacy. Additionally, many relationships fail because they were based on impressing each other too much.

The break for this suffocating pattern can be crisis. Crisis can bring one to self-revelation. It can break one away from image and time/task pressures and connect one with others. Through crisis two people can both come to see the "democracy of failure and intimacy" (Bensman, 1979). This can lead to the breakdown of defenses and to the discovery of "true friends." The empty nest and mid-life crisis are two such crises that bring about re-evaluation and serve to either highlight deficits in relationships or call them to greater levels of intimacy (Lowenthal, Fiske, & Haven, 1986). Therefore, during this period, the middle age reduce the number of their relationships and people seek relationships of pleasure and intimacy rather than frustration. "Consciously or unconsciously the realization sets in that time is short and life is precious, that touching and being touched by other human beings are not to taken for granted" (Benton, 1974). The realization occurs that many relationships are not intimate and enriching, and time is far too valuable to continue in those relationships.

Thus in mid-life one can be either isolated by aloofness and position or come to grips with the universal of frailty, and in so doing touch others and experience intimacy.

Older Adults

Growing older can profoundly affect friendships. The stereotypical view is that old people are rigidly set in their ways, and cannot flow with the dynamics of intimacy. The tendency is to "type" older persons as all alike and bored, lonely, passive, and dependent.

The more appropriate way of viewing intimacy and old age is that there is more refinement and selectivity in relationships at this age, and less of a need for a wide range of friendships. People know better what they want in relationships. As we get older, there is greater variability. Many in their seventies are still vital, alert, interested in learning and creating valuable, rewarding relationships with peers and younger people. For one thing, there is leisure for companionship.

Emotional and physical voids may be left by absence of work, declining health and energy, or by children who cannot or do not meet needs. Intimates serve to fill these voids. "Older people with confidants are better able to cope with death of spouse, more apt to have good morale and lower risk in terms of mental health than older people without confidants" (Benton, 1974).

With retirement from work there is some withdrawal from the public world. If one has achieved and withdrawn, there is a freeing from the notion that one "cannot afford to allow their failures, their common biological humanity--these ingredients of deep intimacy--to interfere with their projection of mature success" (Bensman, 1979). There is less cause to defend self and protect place in the pubic world. At this age society is less likely to punish one for mistakes. The older person is free to tell the truth in a way the younger person cannot do. Therefore, a new level of intimate experience can occur, and can be the basis of new kinds of friendship.

The older person then performs an education function of how to interpret the public and private self, models genuineness and integration of self, and perhaps is better able to achieve intimacy.

Conclusions

The conclusions we can draw from this article are that intimacy is a basic need and if we desire to promote survival, growth, and mental health and happiness for ourselves and others, we need to become skilled at how to form psychologically intimate relationships. We need to understand that developing and maintaining such relationships is a gradual and time-consuming process that requires skill and effort. It requires disclosing self, and interpreting the personal self to another. It requires trust, tolerance, and being sensitive to change and expenditures of psychic energy. We need to understand too that intimacy will affect us differently depending where we are in our life course; understanding the peaks

and pitfalls of each life stage can help us navigate each one more successfully, and better achieve psychological intimacy.

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CAREER COUNSELING WITH THE MIDDLE AGE: A GROUP COUNSELING MODEL

Larry Burlew
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Group counseling is a popular treatment modality for exploring client concerns and has been since the early 1950's. John Crites (1981) stated that a group career counseling model has not been developed, even though it is considered a "desirable approach to facilitating career development" (p. 217). With this fact in mind, consider the following:

1. In a survey of colleges and universities, 68% of the sample reported providing small group career counseling (Davis & Horne, 1986); and

2. In the NVGA (1985) vocational and career counseling competencies only two references imply that knowledge of group counseling is a necessary competency for career counselors:

   a. "Ability to use appropriate counseling techniques..." (p. 131);

   b. "Ability to implement individual and group programs..." (p.134).

This information raises some important concerns. Do practitioners distinguish between career guidance and career counseling? If career counseling groups are being conducted, what

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models are being followed? If career counselors use groups, why is "knowledge of group counseling" not a necessary competency for career counselors?

There is a tendency to use the terms career guidance and career counseling interchangeably, which may account for the lack of group career counseling models and stated competencies. Conceptually, there are important distinctions between their processes. In a recent article, Elizabeth Butcher (1982) claimed that there is a "proliferation of articles on career guidance and counseling;" however, most of these articles are "geared toward educational courses, workshops, and seminars" (p.200). This "education, academic, and preventive" focus described by Butcher theoretically resembles group guidance which makes "an indirect attempt to change attitudes and behaviors through accurate information or an emphasis on cognitive or intellective functions" (Gazda, 1984, p. 8). Group counseling, on the other hand, is defined as:

> A dynamic interpersonal process focusing on conscious thought and behavior and involving the therapy functions of permissiveness, orientation to reality, catharsis, and mutual trust, caring, understanding, acceptance, and support. The therapy functions are created and nurtured in a small group through the sharing of personal concerns with one's peers and the counselor(s). (Gazda, Ducan, & Meadows, 1976, p. 305)

Researchers are asking for models that make the distinction between group career guidance and group career counseling (Kivlighan, Johnsen, & Fretz, 1987).

Making the distinction between group career guidance and group career counseling facilitates a credible evaluation of the current research on group work with a career focus. Much has been written about career counseling, with only scant mention of group career counseling methods. Most of the group career literature relates to younger populations (e.g., adolescents and college age students) and group career guidance programs. Articles frequently focus on career courses (e.g., Davis & Horne, 1986; Lent, Larkin, & Hasegawa, 1986). Many articles discuss a small group career guidance format, implying that such constitutes group career counseling (e.g., Davidshofer, Thomas, & Preble, 1976; Feldman & Marinelli, 1975; Schenk, Johnston, & Jacobsen, 1979; Smith & Evans, 1973). Duane Brown (1981) was more exact in labeling group career guidance as a structured group model following a predetermined

outline, usually in the format of classes, seminars, workshops or small group meetings.

Most research cited above focused on career choice, a content focus helping students declare an occupation (Crites, 1981). For example, Schenk, Johnston & Jacobsen (1979) conducted 3 sessions with college freshmen and sophomores. Progressively, the sessions dealt with: (a) planning of career choices; (b) available resources; and (c) integration of information for appropriate choices. They determined that the small group work helped students make gains in occupational information and decision making skills.

Unfortunately, research related to group career counseling, as defined by this article, is scarce for every population. Davis & Horne (1986) completed a study comparing both a small counseling group and a career course as treatment with college students. The "group career counseling" provided a 12 session, content specific counseling treatment. Pertinent topics such as self-knowledge and interests were subsequently introduced, while each session encouraged group interaction, discussion, feedback and sharing, common characteristics of small group career counseling (p. 259). Both formats were found to be equally effective in changing the level of career indecisiveness.

John Crites (1981) in his text, Career Counseling: Models, Methods and Materials, devotes two pages to group career counseling. He does propose an approach to groups which focuses on career choice process (i.e., the specific steps the individual takes in arriving at career choice content), rather than on career choice content itself (p. 218). By focusing on the process which they experience, clients in a group can actually interact by focusing on critical attitudes (e.g., involvement in career decision-making) and competence (e.g. self-appraisal) related to career choice.

Programs developed to facilitate career decision making do not necessarily address the many age-specific career development issues which midlife adults bring to the career counseling process. These approaches are very limited and refer to those clients in the process of making a career choice or change. Consider, for example, the midlife woman who is concerned (and anxious) about childbirth and the effect of a 6-12 month hiatus on her career progression. Will the above approaches meet her needs? Not all mid-career counseling issues require an occupational change, but rather require possible discernment and recommitment to current career choices.

Conceptually, mid-career counseling should provide individuals the opportunity to explore the pertinent developmental issues of their epoch.

Elizabeth Butcher's (1982) approach to group career counseling is more applicable to the midlife woman's concern above. She suggested that "career counseling efforts need to extend beyond the immediacy of finding a job or selecting a school to considering the client's long-range goals and lifestyle preferences" (p. 201). She specifically applied her model to "clarifying one's occupational potential and preferences" (p. 207), which implies a process of career decision-making or change. Nevertheless, Butcher's model provides an adequate base from which to propose an approach or model to group career counseling with midlife adults.

The remainder of this article will focus on the following three issues:

1. Which career developmental issues might midlife adults address in group counseling? These issues seem particularly important with regard to Herr and Whitson's (1979) statement: "Career guidance with adults has become a national priority" (p. 111).

2. What are the pros and cons of providing group career counseling with the middle age?

3. How can an approach to group career counseling be conceptualized that focuses on any problems or concerns related to a person's career?

Career Development Issues at Middle Age

Donald Super is one of the earliest and most respected career development researchers. According to his career development model middle age is between the ages of 45-65, even though other models posit that middle age begins as early as 35 (Kastenbaum, 1979). In Super's (1957) model, the stage of middle age is labeled Maintenance. In the previous stage the worker earns a place in the world of work and in Maintenance he/she begins to enhance and secure that place. Originally, the major task was "preserving achieved status and gains." More recently, Super (1984) described the "cycling and recycling of developmental tasks" and listed the following as the tasks for middle age:

1. Focusing on essential activities
2. Holding own against competition
3. Developing new skills
4. Identifying new problems to work on
5. Accepting one's limitations. (p. 203)

In other research, David Wortley and Ellen Amatea (1982) also summarized career developmental tasks of adulthood. In their schema, middle age is between the ages of 40-60. They labeled developmental tasks as either exterior or interior. A list of their tasks follows.

	40-50	50-60
Exterior	-entering period of peak work -assuming mentoring functions -possible midlife career change	-career culminating -ensuring retirement security -age-related employment problems
Interior	-redefining work role/goals in light of changing values/priorities/possibilities	-beginning to disengage from work -reviewing and evaluating work accomplishments

(Wortley & Amatea, 1982, p. 480-81)

From a career perspective, middle age can be either a time of challenge and growth, or one of turmoil and conflicts as evidenced by the recent surge of literature on the "midlife crisis." The above research supports the reality that developmental tasks occur at every stage of development, and they can cause anxiety and crisis. Counselors who are unfamiliar with the specific career developmental tasks relevant at each stage may overlook developmental issues underlying presenting problems. The following examples demonstrate how client concerns impact career developmental tasks.

Reduction in force (RIF) due to technological change, obsolescence, or corporate mergers is becoming a commonplace occurrence (Hayslip & VanZandt, 1985.) These events precipitate the external task of forced career change. However, certain internal

developmental tasks would be affected by the forced career change. Internal tasks affected include: a person's feelings of self-worth as they are "entering a period of peak work commitment;" re-evaluation of disengagement; change of perceptions regarding "work roles, priorities, and values." If counselors limit their interventions with midlife clients being rift to providing workshops on job change, job search, resume writing, and interview skills they will overlook the deeper, developmental components of the client's situation.

Another problem reported at middle age is "updating professional competencies in midlife so workers don't top out" (Dubin, 1974, p. 152). Those midlife workers who fail to "update," may be faced with a "forced career change" due to obsolescence. Therefore, their problems would be similar to the scenario above, as well as being forced to "develop new skills." Sending these clients for occupational retraining again fails to recognize the more subtle, internal conflicts that may exist and impede further, successful career development.

According to Cherlyn Granrose (1985), childbirth and returning to work are emotionally laden issues for some women. Because many are having children later in life, midlife women may be faced with "unexpected concerns and anxiety" related to conflicting life roles. Childbirth may impact a woman's plans at midlife for "holding own against competition," a major developmental task.

Contemplation of their post-partum return to a worker role may raise the following concerns: (a) After a 6-12 month hiatus can I return to the same "high-powered" position?; (b) Will other executives still see me as a serious candidate for promotion?; and (c) After childbirth can I resume my former pace, or must I compromise my corporate ambitions for my newer motherhood role? While this client may benefit from an education program which teaches coping skills to women with combined roles, that alone may not address her deeper conflicts.

Obviously, midlife career concerns are complex and involve other factors not related to the work setting (Brown, 1981). The above are samples of the concerns or crisis occurring at midlife which directly impact successful accomplishment of career developmental tasks. A few others noted by the senior author during his years of practice include: women returning to the work force; disillusionment with the world of work; feelings of emptiness with regard to life career role achievement; fear of making a final

commitment to the maintenance stage; depression over being "Superwomen"; distressed husbands agonizing between nurturing their families and "maintaining" their current work status; sadness resulting from never being mentored, while feeling inadequate to mentor; fear when realizing that earlier goals may never be reached.

The issues addressed above create anxiety and crisis for the midlife adult. Dealing with them from a pure guidance perspective would be a disservice to the client. Trying to make an "indirect change by emphasizing cognitive functions" may never address the real problems. A more direct counseling intervention is needed. Until recently, one-on-one career counseling was the most reported approach. Group career counseling is a viable alternative.

Pros and Cons

Many reasons determine whether or not a client should be placed in group counseling. Gazda (1984) recognized the following advantages to group counseling: "approximates a real life situation, provides for more economical and better use of counselor's time, can use peer group pressure, and implements subsequent individual counseling"; the following are disadvantages: "inappropriate treatment for certain problem types, permits certain individuals not to participate, does not provide adequate individual attention, and may cause some to drop out of therapy prematurely due to level of group comfort (pp. 28-29)." Ohlsen, Horne, & Lawe (1988) observed that counselees are encouraged to discuss their problems in a group when they observe others doing the same.

Gazda's pros and cons relate specifically to group counseling; hence, they also relate to group career counseling. However, only a few examples are highlighted and discussed below.

Pros

1. Approximates a real life situation. Adult learning theory demonstrates that adults value utility and applicability in what they learn (Knowles, 1978). Middle-aged workers don't usually have a "powerful" expert, such as a counselor, who carefully and intensely helps them work through their career problems, but are typically working through these issues with peers in the lunch room, during a meeting, or over a beer. Therefore, the group situation approximates their on-the-job experience. Additionally, they receive feedback on their group performance, try out new life career roles,

and discuss career concerns with members who resemble their daily peer contacts. Therefore, middle-aged clients may perceive group counseling experiences to be more transferrable to their work world.

2. Identification of common problems. At midlife, workers are supposed to be responsible, in positions of power, wiser and experienced, and mentoring (Burlew, 1989). In many instances these individuals may feel isolated upon reaching the crest of their performance. The younger and less experienced worker is racing to achieve and looking to the midlife role model for advice, while the older worker is decelerating and declining occupationally, leaning on the middle-aged worker for support. Midlife workers may believe that they should "appear powerful and able." Their reluctance to reach out may leave them feeling isolated. Once in group career counseling, middle-aged clients may experience relief and support knowing that others share not only their career pressures (e.g., mentoring, topping out), but also their isolated feelings.

Cons

1. Getting the middle age into counseling. Many of today's middle-aged population may stubbornly cling to the medical model of therapy, relegating it to the sick or mentally ill. Thus, they may be reluctant to seek or enter any form of therapy. Career counseling is no different. As a matter of fact, Janet Armstrong (1981) reported that "midlife adults are deciding to change the direction of their careers...yet in a survey of midlife adults, only 14% reported using counseling or career planning services in the last five years" (p. 205). If middle-aged workers need to view themselves as "powerful and capable", then divulging their "perceived lack of ability to deal with their own career concerns" to a small group of their peers may be more threatening than one-on-one work with a counselor. Because many adult workers suffer through the pain of a mid-career crisis without identifying themselves, it is also difficult to find and group them together.

2. May Not Provide Time For Individual Attention: Midlife adults have extensive work histories, multiple career life roles, varied leisure experiences, and different levels of career maturity. Grouping of clients tends to be on similarity of career issues, not on client characteristics like those listed above. Therefore, individual career development differences may be overlooked in a group setting because of time limitations. If the group is unable to address the unique characteristics of individual members because of time limits,

then it is the responsibility of the leader to identify these characteristics and recommend individual counseling for such clients, after the group terminates.

Group Career Counseling: A Model

Many researchers have written about aspects of group counseling (e.g., Corey & Corey, 1977; Gazda, 1984; Merritt & Walley, 1977; Yalom, 1985). A few pioneers have written about group career counseling (Brown, 1981, 1985; Butcher, 1982; Crites, 1981; Feldman & Marinelli, 1975; Herr & Cramer, 1984). The group career counseling model proposed below is a synthesis of all the research. The goal of this article is not necessarily to innovate, but to provide career counselors with a specific model for career groups.

Group Career Counseling: A Process Model

The model is explained in stages, broken down into steps, and these are briefly described below.

Stage 1: Establishing a need. While group guidance is preventive in nature, group counseling focuses on specific identified problems which are brought to the counseling process. Counselors may "see" a need to organize a group from the problem similarities of their individual clients or from other, less direct means (e.g., reports from supervisors).

Stage 2: Setting a metagoal. After establishing a need, the counseling group is given definition by its metagoal, the "umbrella" reason for its conception. Such a metagoal might be: "Developing coping strategies for middle-aged women who are contemplating the effects childbirth might have upon their careers." In addition to the metagoal, a personal goal(s) is formulated for each member. For example, one client may want to explore her fears of diminished status following the birth of her child, while another may be apprehensive that combining roles may cause her to lower her performance standards.

Stage 3: Identifying clients. The simplest way to identify clients is through the counselor's private practice or agency work. However, many prospective middle-aged clients experience pain and stress in their work environments, yet are unaware that help exists. Therefore, an effective community counselor needs to approach medical doctors, corporate personnel representatives, and leaders of

community organizations like the PTA to discuss the establishment of the career counseling group and to locate possible referrals. One may even advertise in appropriate publications and company newsletters, assuming it is clearly stated in the advertisement or the first personal contact that group career counseling will occur.

Stage 4: Screening of clients. Career counseling groups follow the same selection processes described by Yalom's (1985) Chapter 8 and 9. Career counselors request additional information related to: work and leisure experiences; life career roles; career development assessment, particularly vocational maturity. This information helps the counselor understand the client's unique career skills and development, such as level of vocational maturity, which can inhibit or enhance the client's group performance potential.

Stage 5: Arranging the environment. The procedures of this stage also resemble those recommended by other group counseling researchers (see Gazda, 1984). An ideal group room would be adjacent to the career resource center, facilitating easy access for middle-aged workers unfamiliar with locating career resource materials. Eventually, clients can be sent on visits to libraries, college career centers, etc., teaching them to locate resources on their own.

Stage 6: Conducting the group.

1. Developing interest and involvement. Initially, the counselor must get to know his/her clients and begin to establish rapport, through good listening and counseling abilities. The leader strives to model effective interpersonal skills and to achieve some level of group cohesiveness. Early in this step the leader: (a) gives a clear, working definition of career as the sum total of a person's leisure and work activities (McDaniels, 1984); (b) reviews the metagoal; and (c) discusses ground rules.

Although adults often regard ground rules as common courtesies which need no discussion, these vital dialogues assist clients in developing responsibility to and ownership of the group. There may be ground rules which are specific for career groups, such as how much can I discuss with the supervisor helping to plan my career path?

Initial group activities and exercises should have a career focus. Discussions can be initiated on topics like: the ideal job; my

greatest fears related to my career; or the happiest moment of my career. These early exercises focus the members and facilitate becoming acquainted with other members as workers and leisurites.

2. Clarify the problem. Ultimately, a career concern is a personal concern, touching other aspects of a client's life. The senior author depicts the clients' problems as wagon wheels with spokes protruding from the center. With the help of the group, each client clarifies his/her own problem (the center) by identifying the many components (the spokes). Returning to the earlier example, a woman who fears that childbirth will reduce her status among peers and executives may have spokes emanating from her center relating to: her competence and worth as a worker; assertiveness; role conflict between husband/father and wife/mother roles; making decisions about prioritizing time; and changes in career path due to the assumption of a new role. After the group is encouraged to assist the client in identifying and illustrating her wagon wheel, representing stressful components with larger spokes, the group helps the member decide which spokes need immediate attention.

3. Assessment. Data collection is a central activity of the group counseling process. Members choose their most pressing problems for discussion and begin the process of data collection. Part of this process includes assessing the group dynamics and the revelance of such to client problems.

The female client above may choose two problem components to discuss in detail: her competency and worth as a worker and how she will spend her time after childbirth. Therefore, relevant data collection for her may include: previous performance evaluations; personal discussions with supervisors; her observations of other women making similar transitions; her perceived ability to complete assignments; nature and duration of work duties; and leisure pursuits. Whether the data is collected qualitatively or quantitatively, the group plays an integral part in collecting this data.

4. Individual interpretation session. In order to address the uniqueness of middle-aged clients, the senior author believes that individual sessions should be arranged to interpret the data collected during the group process. These individual sessions may alleviate situations in which an identified client becomes the focus of many sessions, because he/she has special needs. Together the client and counselor can determine if the client is still on target and remains

suitable for the group process, etc. Clients should gain further insight into their career concerns, and the results are shared with the group.

5. Group sharing session: Interpretation results. At this step clients should return to the group ready to share what they have discovered about themselves as a result of the group experience, recent insights concerning their problem(s) and revelations about their status with the group.

6. Developing treatment plan. After the members have clarified their problems, conflict resolution is addressed. The leader should review the concept of a career plan because most members will make changes in their career plan as a result of group participation. Members can explore alternatives to resolve conflicts and choose alternatives that seem realistic to them and the leaders.

7. Developing plans of action. After deciding upon treatment plans and choosing alternatives, goals should be set and plans developed for reaching them. Techniques such as role plays, homework assignments, and personal interviews, etc. may facilitate members working through their problems. Continuous re-evaluation and adjustment of goals is necessary.

8. Individual evaluation sessions. As the group nears conclusion, members should be seen individually again. Members review their feelings about their accomplishments, and what is left undone. In the example of the middle-aged female, she may realize during the evaluation that a career issue she hasn't addressed is low self-esteem on the job. Individual career counseling may be indicated.

9. Group sharing session: Evaluation results. Clients again return to the group to share their newfound awareness. At this point the group can decide how much longer it will meet. A realistic counselor will help them avoid the "we don't want to separate" syndrome.

10. Termination. At the conclusion of the group counseling experience it is effective to review the members' career plans and discuss the changes and revisions they have made. Long range goals and plans for achieving them should be included. Group members can also discuss how they can "pass on" (i.e., mentor) what they learned about career development while in the group.

11. Follow up. Within a specified time the group leader should recontact the members to determine how they are progressing toward their long term goals.

Conclusion

The group career counseling model reviewed is a guide or format for group career counselors, particularly for counselors unfamiliar with the group career counseling process. If the group and/or counselor contracts for a specified number of sessions, then the counselor must determine how many sessions will be spent on each step of the process. This is a process model, which assumes that because of the uniqueness of each individual, members will proceed at different rates through the different stages of the process. Sensitive group counselors must not underestimate the dynamics of a group, which provide members with the perfect opportunity to gain personal vision through the eyes of their peers.

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BRIDGING THE GAP BETWEEN THE PSYCHE AND THE SOUL

Patricia J. Price

The most frequently stated reason I have heard from clients entering psychotherapy has been "I want to be happy." "Happy" is different for each person but ultimately translates to "I want peace of mind." This article addresses effective techniques of assessment, treatment, and attaining peace of mind by psychological and spiritual growth. It reflects my view of the common ground between psychotherapy and the perennial philosophy of spirituality.

The techniques discussed in this article are aimed at alleviating mental suffering and helping others develop more effective ways of coping with life conflicts and stress. The development of spirituality is one way out of suffering and ultimately is the process which bridges the gap or separation that is felt when one is caught up in suffering. Traditionally, religious beliefs have been left outside the counselor's office (Stern, 1985). Until the recent interest in Eastern philosophy, meditation, and other practices, spirituality was sometimes regarded in our Western culture as pathology. Part of this view was that many people tend to become rigidly obsessed with religion and religious rituals to such an extent that the term "spirituality" was misunderstood as meaning the same.

Spirituality as used in this article is a feature of perennial philosophy believing that: (a) a part of the universal Higher Power of God exists in the consciousness of each human being, and (b) consciousness exists as a hierarchy of dimensional-levels, moving from the lowest, densest, and most fragmentary realms to the highest, subtlest and most unitary one (Wilber, 1977, 1982).

For clarification, the term psyche as used in this article refers to the mind, the ego, the function that calculates, computes, worries, and produces thought (Harre & Lamb, 1983). The soul has been called our spirit, our higher self, that part of us that is at peace with

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itself, the mind, and the universe (Harre & Lamb, 1983; Wilber, 1977). It is both masculine and feminine. The psyche produces thoughts that manifest in emotional suffering as it is pleasure oriented and wants instant gratification. It is adept at making excuses, geared to win, often forms attachments to substances or relationships. It has the ability to keep us in bondage, but paradoxically, it is our vehicle to the soul. It can be our comforter and friend as it steps out of sight to allow our soul or higher self to show itself, permitting us to experience bliss and unconditional love.

There are truly many conditions in our daily lives that cause suffering. They usually fall within the following eight categories:

1. relationship problems (family, loved ones, co-workers, etc.)

2. psychological problems (need to have or not to have attention, to be right, to be in control, to be perfect, to please, to be a victim, to change others, to alter our consciousness)

3. emotional problems (needing to suffer or needing not to suffer)

4. behavioral problems (risk-taking or self-destructive behaviors)

5. lifestyle problems (choosing problematic lifestyle)

6. substance intake (food, chemicals)

7. ego/mind (see definition for psyche)

8. body (physical illness). (Whitfield, 1985)

Since the goal of psychotherapy is to activate values and beliefs into action, it is helpful to explore religious convictions with the client to get a sense of "where he/she is at." This can be done in the clinical interview and by listening for verbal clues indicating from what stage the client is operating. This can eliminate developing a treatment program that is "ahead" of the client's grasp.

One way to simplify this principle is to compare the development of spirituality with other developmental paradigms, such as physical or personality development. Generalizing the

example of physical development, one can understand the concept of providing information that can be "digested" and will nurture each stage of development.

The psychologist, Abraham Maslow(1964, 1971), is known for his theory of hierarchy of needs for becoming a fully functioning individual. Needs range from the lowest, survival and safety, to the need of belonging and feeling love, to the higher stages of healthy self-esteem, self actualization and transcendence. A spiritual hierarchy of values complements this list, having lower levels, and corresponding higher levels (Campbell, 1975; Ram Dass, 1974-83; Small, 1982,).

A comparison of these two models indicating stages and symptoms of need follows:

Maslow's Needs and Levels of Consciousness Leading to Self-Actualization and Spirituality Development

1. Physiological (food, shelter, wellness)	1. Survival (physical healing, overcome addictions, healthy diet, exercise)
2. Safety	2. Passion (needs emotional healing, handle, use feelings constructively)
3. Belonging-Love (emotions, sexuality)	3. Mind/Ego (needs education, self analysis)
4. Self-esteem (mind, ego identity)	4. Acceptance/Heart (needs to accept, forgive, grieve, detach, resolve conflicts)
5. Self-actualization	5. Understanding (needs to pay attention to intuition, be openly receptive)
6. Transcendence	6. Compassion (needs to share, support loved ones)
	7. Unity Consciousness (give and receive unconditional love)

Survival

Survival represents our most primitive level of consciousness. It comes from our will to live and is an instinctual drive for self-preservation and reproduction (Neumann, 1971). It concerns obtaining food and shelter, our bodily functions and the prevention of disease. Today the problem of operating from this level is the risk of being addicted or overly attached. People operating from this level may be fearful (of not having needs met), paranoid, mistrustful, alienated, hopeless, negatively childish, seeing things as "black or white", often becoming physically ill. The treatment or solution is to help the person to achieve abstinence from substances, to provide a healthy nutritious diet, eating regularly, and exercising regularly.

Laughter

Laughter and a sense of humor can help a person work through this stage. Laughter is closely related to crying, because both processes open channels to our higher consciousness, and both help us to feel better, possibly by a combination of ventilation of emotions, stimulation of endorphin release in the nervous system, and by unknown mechanisms. Humor and laughter can be an effective healing agent, with no detrimental side effects (Cousins, 1979). They can control both physical and mental pain in four major ways: (a) by distracting attention; (b) by reducing tension; (c) by changing expectations and (d) by releasing endorphins. Some describe laughter as a form of "internal jogging" because laughter exercises the heart, circulation, lungs, and muscles. When it subsides, the pulse rate drops below normal and the skeletal muscles relax (Peter & Dana, 1982).

Passion

The second level is passion. This emerges out of the will to feel and represents a range of emotions from pain to pleasure. Passion is related to self-gratification (Small, 1982). To master this level one needs to experience feelings and identify, ventilate and process feelings in a healthy manner. Like caring for our physical needs, constructively handling our most primitive feelings is a spiritual act that pushes us into higher, more mature realms. This is a major hurdle and people who become stuck at this and the next level view feelings as a great bother, or worse, as an enemy. Many people have a block, or are out of touch with their feelings. To overcome this condition we should help the person learn how to (a)

experience, handle and use feelings constructively; (b) learn to be assertive, and (c) let go of feelings, such as anger or grief, that are blocking the inner peace of the soul. For most of us, this is a life-long task that improves with practice.

Music

Music can serve several useful and therapeutic purposes. It can help us at this stage to experience all levels of consciousness and can help bring out repressed emotions (Halpern & Savatz, 1985).

Psyche/Mind

The mind has studied itself over the ages and has produced hundreds of views or maps of itself. The psyche/mind usually stays busy both producing thoughts and ideas, and analyzing. It desires to be right, is competitive, useful and aids our very survival; yet can reject parts of itself, usually the parts it judges to be "not right" or "not good" which Jung called our shadow (Small, 1982). Mastering this level appears to be more difficult than previous levels because here, one needs to produce and practice constructive and healthy positive thoughts. The psyche can produce difficulties and bondage, and at the same time have the power to liberate the suffering. People who are blocked at this level are attached to status, competition, often seeking material goods, have a need to be right, and are overly defensive and righteous (Whitfield, 1985).

Control is perhaps the most dominant issue in releasing this stage. Some people fear that if they are not always in control, they will dissolve, disintegrate or die (Cermack, 1985). It appears they get caught up in a vicious cycle of progressively losing control and reacting to it by wanting and needing more and more to be in control. They watch their life and spiritual closeness disintegrate before them. Another word for control is attachment. Sages teach that attachment, or needing to be in control, is the basis for suffering (Welwood, 1983). The one alternative that nearly consistently relieves our suffering is to surrender. Surrender, which in our lower mind means losing, is thus rejected. The correct way to view "surrender" is to see that surrender means "winning." It is winning the fight to control, winning the peace of mind that comes when we give up trying to dictate life itself. Surrender is a freeing to now be a co-creator of life, free to live in harmony with God, not struggling to control God. So another paradox is that by giving up control, one is in control.

While meditation is mentioned in most stress management books, it is not generally discussed as being a spiritual practice, but more as one for relaxing and decreasing tension. However, meditation is one of the most effective practices to quiet the mind and open the heart and higher levels of consciousness. While there are many types of meditation and other practices are meditative, from daydreaming to yoga, common to them all are a focusing away from and letting go of the ordinary mental activity of our ego. Christ meditated regularly, and for us to do so is quite comfortable and compatible with being a Christian. Some obsessive-compulsive people might be too closed to a new experience, or if they do, may be over-zealous in their efforts (Whitfield, 1985).

Prayer

Prayer is a religious practice that is often left out of traditional psychotherapy, but is very similiar to meditation. Many members of the most rigorous religions and other spiritual orders seek an almost identical communication with their Higher Power (McKeon, 1983).

Acceptance/Heart

This stage actually covers awakening and acceptance. Awakening occurs when we get the first glimpse that "things" are not the way we thought they were (Ram Dass & Levine, 1977). A metaphor for this "awakening" might be "Wake up and smell the roses." Acceptance occurs when we accept and forgive ourselves, our pasts, as well as others.

Acceptance

Acceptance causes considerable conflict within the psyche. The paradox of harmony through conflict is difficult to internalize. The psyche keeps pulling back, to be right. Paradoxically, this does not ease suffering, it only produces more worry, guilt, or troublesome feelings. Sometimes, a person has to experience a great amount of emotional pain before they are willing to listen to the message of forgiveness. The attachment to this stage appears to come from the emotional ups and downs of the conflict, frequently regressing to the passion level. The danger of becoming stuck here is to become addicted to conflict. It is helpful to use psychological techniques

that provide a healthy sharing or support system, and to encourage the continuation of spiritual practices (Joy, 1979).

Accepting what is and letting be are part of giving up control and the beginning of detachment. Detachment involves letting go of our expectations, of wishful thinking, and of always wanting things to be otherwise than they are. It also involves forgiving others, forgiving the self, and being patient. Thus, our ultimate detachment is from our own ego or psyche.

Forgiveness

By forgiving, we can give ourselves serenity. The psyche, in its attachments, keeps us feeling guilty about the past and fearful of the future. This preoccupation can maintain anger and resentment at others and at ourselves. There are many terms for unventilated anger (e.g., anger turned inwards produces depression, ulcers, physical stress on the body) and eventually it is crippling. Jampolsky (1982) described ten pathways to inner peace through forgiveness: 1) forgive your parents, totally and consistently; 2) forgive everyone and yourself; 3) forgive nature, the weather, and other conditions; 4) let go of all concepts of God; 5) let go of your rational mind, and trust in love and in God; 6) choose to experience peace rather than fear; 8) choose to be a love finder rather than a fault finder; 9) choose to be a love giver rather than a love seeker, and 10) teach only love, for that is what you are.

This process can be accomplished directly or indirectly in psychotherapy. It is a lifelong process, usually because the people closest to us are those with whom we will experience the most conflict, and the closest of all to us is ourselves, whom we have the most difficulty forgiving.

Denial

According to Jung's shadow theory, the psyche is impulsive, judgmental of traits or tendencies that are disliked and reject them to such an extent for ourselves, that the perceived negatives are projected onto others or onto the universe (Hampdin-Turner, 1982; Jung, 1965;). A good deal of energy is spent in denying parts of our personality, so much so that a chronic belief is created, that something is wrong or bad with our inner beings. Therefore we feel that we are not good enough to be close to the soul/God (Kubler-Ross, 1975). A projected shadow trait that is not experienced in a healthy manner generally becomes a symptom, such as anxiety,

boredom or fear (Wilber, 1979). When we give ourselves the freedom to feel depressed, anxious, rejected, hurt or embarrassed, like inviting the symptom right into our homes and accepting that part of the whole person, the problem tends to disappear.

Understanding

Few people become this level of consciousness very regularly, even today. However, more people are becoming aware of this and higher realms at a younger age (Wilber, 1982). This level can be described as "natural knowing", intuition, and wisdom that usually comes with age. When we operate from this level, the person is creative, from which it is likely that most of the great discoveries - both scientific and otherwise - and creations of humankind have come. This is because the psyche puts worries aside so that the experience of freedom to become who we really are, true creative expressions of a higher power, can emerge. If we allow the psyche to interfere it will dampen creativity and our spiritual experiences because it will try to understand intellectually those things that are abstract, emotional, and from the heart (Holden, 1987). Although this is a wonderful level, the person who becomes stuck at this level may manifest a "letting go" to such an extent that they neglect to take care of the lower self and the "rational" aspects of their lives. To experience this understanding and to prevent overdoing it, pay attention to your intuition, wanting and valuing it, learn to quiet the mind and focus your attention on what you want to attend to, being quietly and openly receptive to whatever comes.

Communication

Communication is a key concept linked to the word understanding. Communication requires listening, which is a manifestation of love (Peck, 1978). True listening requires total effort because you cannot listen and do anything else at the same time. Communication often involves risking openness and vulnerable communication allows us to learn about ourselves, thus it is healing. Risking nearly always involves trust which is in itself a spiritual practice. It also involves letting go, suspending our beliefs.

Dreams

To aid communicating with ourselves, it sometimes is helpful to keep a dream journal. To participate more consciously and make use of our dreams, there are many techniques available that aid in

creative dreaming and dream analysis (Sanford, 1982; Williams, 1980).

Touch

A touch communicates on a deeper level than words. Touching gives us reassurance that we are not totally separate and totally alone, even if for only an instant (Leonard, Rhymes & Solnit, 1966; Oates, 1984). It is an anchoring device for communications and can, at times, be a link to our unconscious (Brandler & Grinder, 1979). There are some people who have difficulty touching and are often out of touch with their own bodies. They are blocked in this crucial part of relating to themselves. Bodywork, ranging from exercise, therapeutic massage, to yoga, can be an effective remedy (Carter, 1983; Ryan & Travis 1981).

Stress Management Techniques

Guided imagery has many uses and can have the same therapeutic and healing effect as experiencing something outright. Systematic desensitization, resolving inner conflicts, biofeedback, and creative healing utilizes this technique as does stress management techniques, regression, and hypnotherapy (Gendlin, 1978; Jaffe & Bresler, 1980; Williams, 1980).

Compassion

Compassion is concerned with empathy, altruism, love for our fellow sufferer, and wisdom. Being compassionate involves letting others be, letting them go when they need to go their own way. Compassion is a major component in tough love. Starratt (1979) said: "The compassionate person knows the pain that rises out of our flawed human nature. He doesn't expect people to be always truthful, always brave, always understanding, always kind, always pure, always faithful, always competent, always successful, always right, always in conformity with any ideal you can imagine. The truly compassionate person sees and responds to the limited, dark side of human existence. He looks upon our universal human imperfection with profound pity and experiences an urge to be helpful where he can. He cares for others because they are human, and being human, he knows that everyone suffers at some time or other and he wants to help. He is in touch with his personal failings and limitations but does not let this knowledge cause him to feel contempt for himself. Mastering compassion consists both of letting go of Passion and at the same time balancing the two. It is

part of the whole that is both suffering and joyous. Sharing, belonging and supporting with our friends and loved ones can help us master compassion."

Unity Consciousness

Most of us are divinely ignorant about this level, yet it is what we seek (Free John, 1984). Reaching a unity has been a goal of most spiritual and religious people. Some people say they glimpse this in a near death experience, or other powerful experience (Moody, 1976). Others say we attain it in a split second, if we can open ourself to being it. A Course in Miracles (1975) suggests that while on this earth, Unity Consciousness is pure unconditional love.

Love

It seems illogical that one of the most difficult acts on earth is to give and receive love. It is a major area in most people's lives. Scott Peck (1978) describes love as "the will to extend oneself for the purpose of unselfish, growth inducing, and attention giving, nurturing one's own or another's spiritual growth." The paradox here is that love is both giving to ourselves and to others. It is both giving and receiving. It is present in lower and higher levels of consciousness. It is called "love" but can be recognizably different at each level. For example, on the lower level, "love" is felt to be in love, dependency, and self-sacrificing. It takes the form in the higher levels as a link to a higher power; it becomes a history of a relationship, unconditional, authentic and real.

Love is probably our most healing energy. It is a source we sometimes overlook in problem solving, while we are in our lower selves. Not feeling loved by parents and intimates sometimes convinces people they are not worthy of receiving love. This belief is so painful, the psyche will create the belief that they do not need love, which translates to "I don't want to be loved" and finally "I will reject love, no matter who gives it to me" (Gravitz & Bowden, 1985). You can see how this results in a wall, an inability to experience feelings and emotions, especially love.

Without love, we suffer, feel guilty, experience pain and often project these feelings to others. Studies prove babies will not thrive without love (Leonard, Rhymes & Solnit, 1966; Oates, 1984). While his/her physical body shrivels and dies, the older person's

emotional and spiritual self will show inward symptoms just as devastating.

Summary

We become our own victims and it is not easy to break free of the role of the victim. It usually happens in stages, little by little. The part of us that wants to be a victim is in our lower self, most specifically level two, passion - and the lower half of the mind/ego level. It requires transcending to look back and see the karma that caused our suffering. A Course in Miracles (1975) summarizes this as follows: "I am responsible for what I see, I choose the feelings I experience and I decide upon the goal I would achieve. And everything that seems to happen to me I ask for, and receive as I have asked."

This leads us to join with our souls to co-create our lives at this moment, to write a new story, to utilize the love energy to heal and transcend the psyche.

"Be not confronted to this world but by ye transformed by the renewal of your mind." - Romans 12:2

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SELF-EFFICACY AND ADULT WOMEN

Patricia Y. Leonard

The concept of self-efficacy is becoming more common in both professional and popular psychological publications. The purpose of this article is to discuss the concept of self-efficacy and its application to adult women. This discussion will include a summary of self-efficacy theory as articulated by Albert Bandura (1977) and the related concepts of learned helplessness (Abramson, Seligman, & Teasdale, 1978; Hiroto, 1974; Hiroto, & Seligman, 1975) and attribution theory (Rotter, 1966; Weiner, 1974). Since it is beyond the scope of this work to present a detailed analysis of these concepts and the related research, key concepts presented in several major articles will be summarized. The reader is referred to these works for additional information and supporting studies. Finally, the relevance of these concepts to issues and strategies for counseling adult women will be discussed.

A Definition of Self-efficacy

Albert Bandura, noted behaviorist, postulated the concept of self-efficacy as an alternative view of the process by which we explain voluntary human behavior. Bandura (1977) indicated that the traditional connectionist interpretation of behavior which linked responses directly to stimuli and/or held that these reponses were regulated by their immediate consequences, was inadequate. It ignored considerable evidence (Bandura, 1977) which suggested that the behavioral chain included cognitive mediational steps which involved the processing of information and the selection of memory-appropriate responses. The cognition in the acquisition and emission of behavior. Memory allows us to store direct and vicarious experience for later use in assessing, predicting, and responding. Stimuli, rather than directly eliciting behaviors, trigger memories which contain information on probable outcomes of selected responses.

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According to Bandura (1977), symbolic constructions of previous experience (stimuli, behaviors, and their various consequences) become the basis for our selection of responses which we believe are most likely to achieve our desired outcomes. Stored experience provides us with the expectancies that are our means of predicting outcomes to a variety of behavioral responses. Discriminative skills are used to identify salient features of stimulus situations and to make linkages between these current features and those of the experience coded on the actor's memory. Aggregate, rather than immediate, consequences are believed to be influential in response selection such that beliefs or expectations of consequences may be more significant to response selection than the immediate outcome or reinforcement. Bandura's formulation identifies cognition, and hence the individual, as central in the acquisition and control of behavior.

Motivation, which regulates the activation and persistence of behavior, is a function of the cognitively represented expectations of benefit or punishment and/or standards of self-evaluation. Reinforcement expectancies serve to motivate certain responses and to cause the avoidance of others which have been associated with undesirable outcomes. The second source of cognitively generated motivation discussed by Bandura (1977) stems from our efforts to match performance with self-prescribed (internalized) standards.

Bandura's notion of self-efficacy is tied to the idea of cognitively based expectancies. The internal prediction system which guides our behavior includes anticipated outcomes of performance and expectancies concerning our own behavior and its potential for achieving desired outcomes. This latter set of expectancies is termed self-efficacy. Bandura (1977) states:

> An efficacy expectation is the conviction that one can successfully execute the behavior required to produce the outcomes. Outcome and efficacy expectations are differentiated, because individuals can believe that a particular course of action will produce certain outcomes, but if they entertain serious doubts about whether they can perform the necessary activities such information does not influence their behavior. (p. 193)

Perceived self-efficacy influences the range of situations we select (if participation is optional), the level of motivation to respond, the persistence of response, and the intensity of response. Efficacy expectations are hypothesized to vary in generality,

magnitude, and strength. Accordingly, personal efficacy beliefs may be broad or limited in scope, extensive or limited with respect to range of difficulty, and strength or weakness. Bandura (1977) identified perfomance accomplishments, vicarious experience, verbal persuasion, and physiological state as the primary bases for our self-efficacy information.

Performance accomplishment information is derived from our experience with mastery (success or failure) over time and circumstances. Perceptions may be altered by or persist in spite of discomfirming experience. Timing, previous pattern, and the strength of self-efficacy beliefs affect persistency and generalizability. Generally, demonstrated proficiency enhances confidence in one's coping skills and elevates estimates of personal efficacy. However, the complex and idiosyncratic nature of individual coding or interpretation of experience precludes the accurate prediction of self-efficacy beliefs solely and/or directly from performance/outcome observations. Attribution theory (Heider, 1958; Kelley, 1967; Rotter, 1966; & Weiner, 1974) is germane to the variability observed in individuals interpretation of their experience. This will be discussed later.

Vicarious experience as a base for efficacy data is generally less potent than performance. Its impact is enhanced by clear outcomes, diverse models, perceived similarity with performers realism, and other factors known to enhance vicarious learning.

The contributions of verbal persuasion to personal efficacy beliefs are hypothesized (Bandura, 1977) to be weaker than those which are performance based. The credibility of the information source and the occurrence of discrediting experience affect the stability and intensity for these efficacy assessments.

Finally, perceptions of our degree and type of emotional arousal (e.g., level of anxiety or vulnerability) and the resultant expectations of performance decrements or increments provide us with assessment of potential for effective coping or sense of personal efficacy.

Having identified major sources of self-efficacy information, it is necessary to consider how individuals process and utilize the information received. According to Bandura (1977), the ascription of responsibililty for the outcomes of one's behavior depends upon characteristics of the individual's perceptual framework, aspects of the situation in which the performance occurred, or both. Specific aspects of these factors may cause individuals to erroneously

attribute behavioral effects to either personal competency or to situational factors (e.g., task simplicity, luck, help) and thereby develop inaccurate efficacy assessments. The amount of effort or ability involved in successful performance is also felt to affect self-efficacy. Generally success attributed to ability fosters a stronger sense of personal efficacy than does that attributed to effort. The presence of situational aids decreases ascription of personal efficacy. Bandura (1977) also reports that lower levels of self-efficacy are typical of persons perceiving their emotional arousal to stem from personal inadequacies rather than situational factors. The cognitive responses of individuals to vicarious experiences and to verbal persuasion are related to factors mentioned previously in the discussion of sources of self-efficacy data.

Attribution Theory and the Concept of Learned Helplessness

The concept of Learned Helplessness has its origins in 1960's and 1970's research studying the immediate and delayed responses of animals subjected to uncontrollable conditions. Maier and Seligman (1976) provided a review of studies through that year. Human research in this area appears in the literature during the early 1970's and details the debilitative impact of exposure to uncontrollable conditions on subsequent behavior. Abramson, Seligman and Teasdale (1978) stated that the concept of Learned Helplessness (Maier & Seligman, 1976; Seligman, 1975; Seligman, Maier, & Soloman, 1971) best integrates the findings of animal and human research. Their (Abramson, Seligman, & Teasdale, 1978) reformulation of the original hypothesis introduces the concepts of personal vs. universal helplessness, general vs. specific helplessness, and acute vs. chronic helplessness. These refinements support Bandura's (1977) hypotheses on the importance of cognitive processes in interpreting and coding experience for use in guiding future behavior.

The theory of Learned Helplessness suggests that an individual exposed to uncontrollable situations will develop motivational, cognitive and emotional deficits which affect subsequent responding if the individual develops an expectation of uncontrollable outcomes. These deficits are manifested as decreased initiation of voluntary responding (motivation); decreased responsitivity to new information (cognitive); and depressed affect related to feelings of helplessness (emotional). Abramson, Seligman, and Teasdale (1978) felt that attribution of cause for the experienced helplessness is critical to the explanation of the often observed variable response

among individuals to similar "uncontrollable" circumstances. The attribution dimensions postulated relate to the generalizability of helplessness, the extent of damage to self-esteem, and the chronicity of duration of helplessness.

Individuals may identify the cause of their failure to cope effectively or perform adequately on a continuum ranging from their own skill and/or resource inadequacy to factors totally external to them and independent of skill/resources such that success would be impossible for everyone. In the attribution of personal or universal cause to their failures, individuals use expectancies based on the real or hypothetical performance of relevant others as a standard. Accordingly, because attributions of personal helplessness entail negative comparisons to relevant others, such attributions are generally more detrimental to self-esteem than are those relating the inadequate performance to universal factors. Attributions of personal vs. universal helplessness are related by Abramson, et al. (1978) to Bandura's (1977) concepts of efficacy (personal) and outcome (universal) expectancies. They also relate them to Rotter's (1966) internal and external locus of control indicating that the personally helpless usually ascribe failure internally and the universally helpless are prone to feel that their failure was externally based (beyond the control of anyone). It is noted that there is research support for the notion that uncontrollable success (if so perceived) will result in decrements in motivation and cognition but not in depressed affect.

The determination of whether helplessness is global vs. specific and chronic vs. transient is related to the individual's attribution of the cause of the performance. Attribution of performance to aspects (internal or external and personal or universal) regarded as stable overtime and across situations (recurrent) rather than unstable and occasional (intermittent) results in a sense of global and chronic helplessness. This occurs because the individual's expectancy that their inability to affect desired outcomes will persist in the future.

The intensity of affective distress and damage to self-esteem are hypothesized (Abramson, et. al., 1978) to be directly related to the importance the individual attaches to effective coping and the individual's certainty of personal (but not universal) helplessness. Individuals who find themselves lacking the skills and resources (which they believe are possessed by others) necessary to succeed in critical life areas are more likely to internalize their failure than

those who perceive the task as unimportant and/or themselves as competent.

Attribution Theory, Learned Helplessness, and Self Efficacy in Understanding Adult Women

Although adult women have received increased attention in counseling and related literature over the past decade many important questions remain unanswered. Recent publications (Baruch & Brooks-Gunn, 1984; Block, Davidson, Grambs, 1981; Richkel, Gerrard, and Iscoe, 1984) present current research and theory and stress directions and implications for furture research. We are cautioned against the uncritical application of existing theoretical formulations such as stage theories or timing models for understanding the development and transitions of women. These formulations were often based on male and/or socioeconomically limited samples (Gilligan, 1982). Giele (1982a) concluded that study of the interaction of physical factors, personality, social roles, and cultural beliefs is necessary to understand human experience. We must begin to develop frameworks for understanding and counseling adult women which will have descriptive, explanatory and predictive functions. These frameworks must address both the commonalties and diversity of experience and responses among women. Self-efficacy and attribution theories seem to be especially promising in this respect.

There are 22 million women between 45-64 years of age (Block, Davidson, & Grumbs, 1981). Adult women experience numerous transitions and corresponding stresses related to changes in role, cultural and personal values, and physical condition during mid-life and later years. Transitions and responses to them are influenced by personality, socio-cultural, biological, and economic factors experienced by individual women. These could vary by age or cohort group as well as by demographic and other characteristics. Research to date has failed to identify universal characteristics of mid-life women (Reinke, 1985) and it seems unlikely that simple linear chronological models can ever adequately address the diversity of perception and response represented among adult women.

Self-efficacy and attribution theory seem applicable to understanding the behavior of women and their differential responses to the transition/stressors of the adult life period. Women are likely to experience transitions associated with loss of children, loss of spouse, loss or altered financial security, decline of social status, altered personal/social roles, changes in work role, and "adverse"

physiological change. All changes require adjustments but women are not equally adept in their coping ability nor in their resilience in the face of multiple transitions. Those unable to adapt and cope with the inevitable changes and challenges of adulthood will experience higher levels of stress, dissatisfaction, and other symptomatology such as depression. The peak period for female suicide (between 45 and 54 years) corresponds to a life period typically characterized by numerous changes. Substance abuse in women is seen as another response to the stresses of adult life (Block, Davidson & Grams, 1981). Black & Hill (1984) concluded that coping ability is predictive of the successful adjustment of adult women and suggested teaching coping skills. Self-efficacy perceptions mediate coping behavior and may also need to be a locus of intervention.

The self-efficacy perceptions of adult women may be a critical variable in their responses to life's transitions. Attributions of outcomes and efficacy affect motivation, persistence, and self-esteem. Adult women who (by experience or observation) attribute outcomes to factors beyond their control (though potentially controllable) are likely to suffer from low self-esteem and to exhibit depressed affect and helplessness behavior which is either global or specific. It is important, from both research and clinical perspectives, to explore the attributional and efficacy perceptions of adult women. These factors may, as Barnett and Baruch (1984) suggest, clarify diverse affective and behavioral responses to women's mid-life issues.

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CHRYSALIS SHELTERS: A FAMILY VIOLENCE TREATMENT PROGRAM

Sister Michelle Dosch
Jeanette Paasch
Leah Bernstein

Family violence has existed in the United States forever, yet only in recent years have reports of family violence been on the increase. "In the 1960's there was an increasing awareness of the problem of child abuse. In the 1970's people became aware of issues surrounding spouse abuse, and services were developed to meet needs of these victims. The 1980's may be considered the era of awareness for 'elder abuse' " (U.S. Department of Health and Human Services, 1980 in Myers & Shelton, 1987, p. 376). Family violence encompasses a broad range of abuse, including physical, sexual and psychological. As more becomes known about various forms of family violence, researchers are slowly changing stereotypes about perpetrators and victims. Family violence is an extensive and pervasive social problem that occurs across race, class and locality. Although violence may have recurred within families for generations, the violent behavior has remained a family life secret that is hidden behind closed doors (Fergusson, Horwood, Kershaw, & Shannon, 1986; Mathias, 1986; Straus, 1980).

Hitchcock (1987) described physical abuse as a lifestyle. She reported a "cyclical pattern of physical abuse seen through generations of families" (p. 50). Within these families the abuse is accepted as normal, although it leads to developmental deficits and

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inadequate coping skills. She contended that by considering domestic violence and abuse as a learned lifestyle counselors can be empathic.

Obviously, the problems of domestic violence have not gone unnoticed. Women's studies are investigating the reluctance to report the patterns of traumatic bonding in battered women (Bascelli, 1985; Painter, 1985), and the dilemma a woman faces extricating herself from an abusive relationship (Schutte, 1986). Jouriles, Barling, & O'Leary (1987) and Bandura (1973) hypothesized that children learn violent behavior through witnessing interspousal violence. Adler (1986) focused a parent's psychopathology and the characteristics of children which make them more likely to be abused. Azar (1986) reviewed cognitive, behavioral and developmental perspectives to create a framework for understanding child maltreatment. Research has demonstrated that there is a propensity for abused children to become abusive parents (Kaufman & Zigler, 1987). Finally, Myers, & Shelton (1987) called aging a "crisis in slow motion" and discussed the extent of elder abuse in America today. They called for an expansion of support networks for individual older persons and family members responsible for their care.

The seriousness and extent of domestic violence in the United States is a growing concern. A workshop on violence conducted by the Surgeon General's (1986) office directed national attention to the victims of domestic violence, signaling support and encouragement to service providers of these victims.

Chrysalis Shelters is an example of the many existing programs providing a continuum of services and treatment strategies to victimized women, children, and elders. In presenting an overview of these services, this article will address: What is family violence? Where does it start? How long does it continue? Who are the victims? And, why would anyone repeatedly abuse his/her loved oned?

The Battering Syndrome

Like the current authors, mental health professionals working with domestic violence victims see certain patterns characterizing the "battered" population (Farrington, 1986). The backgrounds of many battered victims are replete with child abuse in the form of physical beatings, emotional battering, and victimization by incest (Finkelhor, 1986; Jourilies, et al., 1987; Kaufman & Zigler, 1987).

A large majority (as many as 85%) of women who are domestic violence victims were abused as children. In at least one half of the families where the mother is being abused, the children are also being battered. A high percentage of all male abusers saw their mothers abused or were abused themselves. Battered clients come from generations of family abuse in which no type of intervention ever occurred (Kaufman & Zigler, 1986). Therefore, offering interventions may be difficult with a population not accustomed to receiving help.

When a woman does seek help, the pattern of victimization may be so deep that long-term therapy is required to break the cycle of violence. From the authors' experience, there are three phases in the cycle of violence (see Figure 1): building up of tension, the acute battering, and the making up: loving and love-making stage. The cycle occurs differently and at different levels of intensity for each client situation. Inevitably, however, the abuser becomes frustrated and stressed, yet does not or cannot communicate these feelings. The feelings are ultimately related to feelings of "low self-esteem." When the internal tension becomes too stressful, an "explosion and fight" (the abusive situation) occurs. The batterer, as a final phase in the cycle, feels remorseful and promises that the violent behavior will "never happen again." Eventually, after a period of repeated beatings, the victim develops a sense of the impending battering that she will experience; in other words, she knows when another abusive experience is about to occur.

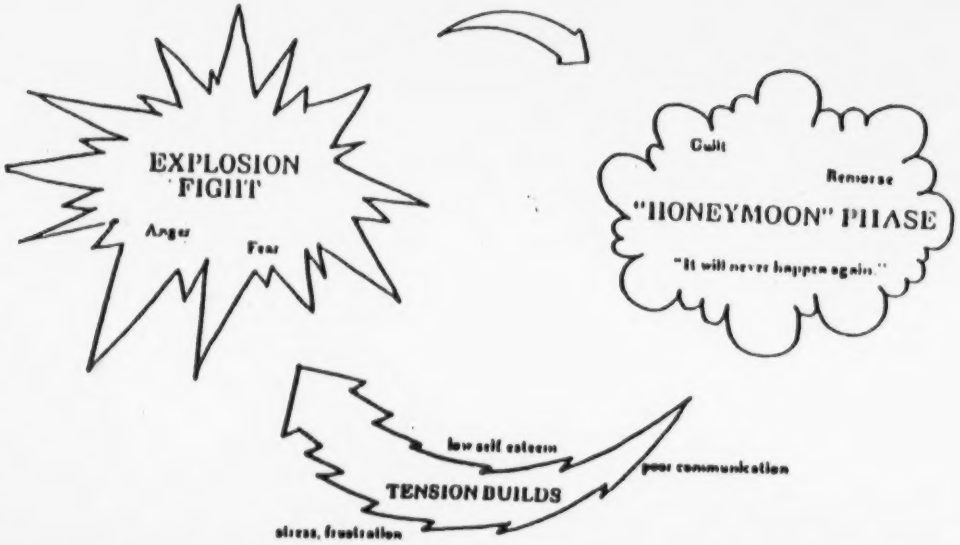
Along with the cycle of violence, there is a continuum with regard to type of family violence. Not dealing with this continuum in a timely manner may result in death, suicide, or rape for the victim (see Figure 2). The continuum of violence includes physical, verbal/emotional, and sexual violence. The consequences of death, suicide, or rape are severe consequences for a woman who has done little but choose to live with the perpetrator. A service provider intervening at any point along this continuum may change the life patterns of the victims and perpetrators.

Chrysalis Shelters: A Model Program

The first type of intervention is generally the police who are answering a domestic violence call. The police inform the victim of the services available in the community. In the authors' situation (Maricopa County), the police check to determine the severity of the situation. If there are no weapons or danger, then the Family Stress Team is called. The Family Stress Team visits the home and

FIGURE 1

Handout: CYCLE OF VIOLENCE



For More Information Contact:

Flagstaff Women's Shelter
309 N. Agassiz St.
Flagstaff, AZ 86001
(602) 774-7363

-The cycle can cover a long or short period of time

-The violence usually gets worse.

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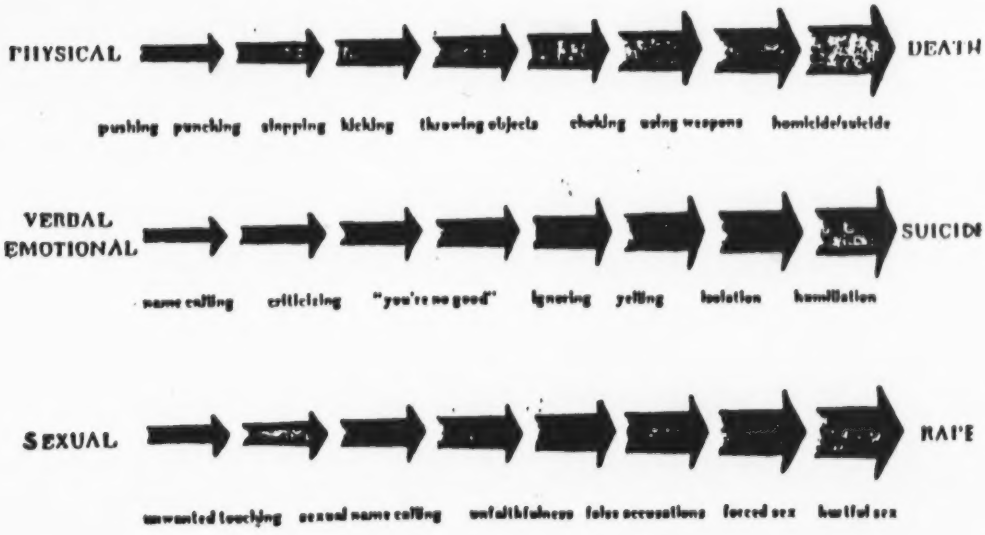
FIGURE 2

Handout: CONTINUUM OF FAMILY VIOLENCE



Without some kind of help, the violence usually gets worse. The end result can be death.

For More Information Contact:

Flagstaff Women's Shel
[illegible] N. Agassiz St

111

counsels the victim. The team informs her/him of community services. The Chrysalis Shelter becomes involved immediately because a staff member is part of the Stress Team.

Many domestic violence victims are then taken to a hospital emergency room. One out of every five women seen in an emergency department is a battered woman, making domestic assault the single most important source of injury for which women seek medical attention. Many victims inform health care providers of the cause of their injuries. Others, however, are hesitant to discuss the battering and may be reluctant to report the abuse due to (a) fear of increased violence or retaliation, (b) because of shame, embarrassment or self-blame, or (c) because of the lack of support from family, friends and community. If community hospitals are treating so many battered victims in emergency rooms, then it follows that hospitals need special programs to meet the needs of domestic violence victims. Having special programs for hospitals in treating battered victims requires educational programs for hospital staff.

As part of the Chrysalis Shelter educational process for hospital emergency care of battered victims, hospital personnel are trained to identify the "battering syndrome" even when the victim does not volunteer the information. Training sessions are provided for the social work staff, emergency room staff, and the paramedics. A Chrysalis Shelter counselor is on a 24 hour call for any woman who wishes to speak to a domestic violence counselor. Along with the professional counselor, volunteer paraprofessionals are trained to work on the "24 hour call program" when the counselor is not available. The training of hospital personnel and volunteers must be an on-going process.

Once abused, a woman may choose to seek the safety and assistance of a shelter. In the authors' geographic location, there are seven shelters in the community, two under the auspices of Chrysalis. The shelters provide a residential setting in which individual and group therapy are offered, along with referral services within the community.

During therapy, many issues are addressed. A woman may be functioning on different levels with regard to various aspects of her life. This is dependent on the length of abuse, the severity, and the kinds of abuse that occur. Although physical battering is devastating to a person, subtle, psychological abuse is just as destructive to the victim as a physical blow. Two major goals of

therapy are to (a) help the client realize the different forms of abuse and (b) recognize abuse when it occurs. In recovery the victim is empowered to gain control over her life.

Because violence is a way of maintaining power and control for the abuser, the client must gain insight into this phenomenon and decide what she wants to do about it. The major focus of therapy is assisting the client in rebuilding her self-esteem and supporting the client in all the decisions required for the recovery process. Some of the issues the client faces are (a) should she return to her home, (b) what are the job opportunities, welfare assistance, and available housing, and (c) a most important issue, can she care and/or provide for her children. After the trauma of abuse the decision-making process is greatly impaired. A woman needs time to recover and reorganize her life. The shelter staff supports the client in her attempt to renew and restructure her life orientation.

An important component of domestic violence intervention at Chrysalis Shelter is the care for children who come with clients. A child therapist counsels the children individually and in groups using the media of art, music and play therapy. Although a child may not have been physically abused, the child is the "silent witness" of the abuse a mother experiences. With the help of the child therapist, this hidden trauma can be unlocked and released so that the child does not stop his/her emotional development because of the violence. Additionally, when there is on-going abuse in the home, the child is not nurtured in an efficient manner because the mother is just trying to survive in the enviroment.

Along with the services of a child therapist, Chrysalis has incorporated a "Rock 'n' Read" Program for their children. Senior volunteers from a local RSVP Program come to the shelter and rock, hold and read to the children. This program has proven very beneficial both for the nurturing of the children and the seniors who volunteer.

After a victim completes a thirty day residential program, she can go into the shelter Transitional Program, if appropriate. This program is funded by HUD and gives the residents three to eighteen months to establish independent living. Believing that victims of domestic violence can recover from abusive treatment in a month is a myth. In most cases, recovery doesn't even occur in several months. Rather, long-term counseling is required to assure any chance of recovery and the establishment of new life patterns and attitudes. A woman has an 85% chance of freeing herself from

patterns of abuse if she has an opportunity to move into a transitional living style.

At Chrysalis Shelter, a strong component for a total program of services to our clients is the Out-Patient Program. Many times women are not able to come to a shelter, yet desire counseling services and knowledge of community resources. The Chrysalis Shelter Out-Patient Program is very much in demand and provides a necessary service to women who are coming to a new awareness of the scope and intensity of abuse in their lives.

Besides the victim, both children and the perpetrators can be helped through the Out-Patient Program. Children are seen to help them deal with the trauma of violence in their family lives. The perpetrators are counseled to assist them in recognizing and "owning" the anger and rage that is part of their coping behavior in conflict situations. Most abusers have been abused in childhood and, therefore, the intergenerational pattern of abuse continues unless a therapist or service agency intervenes. Unfortunately, services available for men at this time are minimal. Unless the lack of services for men, who are usually the perpetrator, is remedied, the hope of recovery for the total family unit is minimal.

Chrysalis has a Speaker's Bureau that addresses many different groups. The Speaker's Bureau provides accurate information to the community, raises consciousness about the seriousness of the problem, and informs the community about the services provided by Chrysalis Shelter.

Finally, the Chrysalis Shelter developed an Elderly Abuse Project that has been working with elderly victims of abuse. Elderly people experience abuse in the form of passive and active neglect, psychological abuse, physical abuse, and financial abuse. Many times the abuser is the caregiver of the elderly person. Because we have generations of people living longer, the caregiving role may continue for many years. Now we have the phenomenon of a seventy year old woman taking care of a ninety-five year old mother. At times the caregivers can be as incapacitated as the elderly person. Chrysalis operates a hot-line for elderly abuse so someone can call and ask for services and shelter for an elderly person. An Out-Patient counselor coordinates this program and provides a support group for caregivers. Chrysalis is beginning to develop a network of "Safe Homes" in which to place the elderly who are abused. The elderly do not benefit as much from staying in a shelter because their needs are much different from the younger

population that is served in a residential setting. This service is very new and knowledge of its availability is not yet wide-spread in the community.

Conclusion

Although the Chrysalis Shelter has experienced tremendous growth in the last two years, the need for services is so great that only the tip of the iceberg has been touched. The public is becoming more aware of the element of violence that seems imbedded in our society. Hedda Nussbaum's story is an example of how the news of domestic violence is permeating television programs, newpapers, and magazines. Her life experience of family violence in the form of brutal beatings and psychological abuse over a period of eleven years was made visible to the world on the December 12, 1988 cover of Newsweek. Her court testimony was covered by all three New York network television stations and the nation watched and listened in disbelief. The conviction of Hedda's partner, Joel Steinberg, in the child abuse and death of their foster child, Lisa, became the central focus of a trial that left participants and observers alike filled with many unanswered questions. The Hedda Nussbaum story has shown us how destructive the patterns of abuse can be.

Hopefully, Hedda's story has not been told in vain. Now the time is right for all professionals in the field of human services and educational systems to examine ways that they can assist the people they serve to live a life free of violence and abuse, something everybody deserves.

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INDIVIDUAL VS. GROUP IDENTITY: A COUNSELING PERSPECTIVE

Stephen Paul Flemming

Counselors should examine the presumption that in working with clients, group identity is an essential place to begin, traverse and end therapy. Additionally, counselors might reconsider the supposition that ethnic or some other group affiliation might be the primary value referent from, through and back to which one's identity flows. Therefore, as a counselor it seems necessary to understand the past and present value that group identity (e.g., ethnicity) plays in the reality of the client's self-concept. What is ethnicity? What is group identity? And where, metaphysically speaking, is its place within the hierarchy, or along the continuum, of the client's total possible identity structure? In other words, what value, in principle, might one's sense of ethnicity (or other group identity) have in the healthful prosecution of one's life?

Definitions

In examining the concept of identity, there was an expectation that some fairly focused, consensus-oriented definitions of the terms involved existed. Not really so. Instead, there seems to be a generally freewheeling array of mongrel, planetary-like constructs, rather arbitrarily fashioned around the concept called "identity." Included in Figure 1 is a partial list of both the individual and group identity-related constructs involved. As can be discerned, such an extensive variety of terms could easily confuse the best of reseachers. Understandably, while trying not to get confused, the present author found himself answering nothing less than the ages-old question, "Who am I" or should it be, rather, "Am I me, or am I we, or am I someone caught between?

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Figure 1

Self	Non-Self	Ego
I	We	Individuation
Individualism	Introjections	Imitation
Internalization	Identification	Group
Race	Ethnicity	Ethnic Identity
Ethnic Personality	Assimulation	Pluralism
Ethnic Mobilization (Theory)	Liberal Individualism	Ethnic Conflict(Theory)
Romantic-Conservativism	Old Ethnicity	New Ethnicity
Fold Groups	Interest Groups	Voluntary Ethnicity
Ethnocultural Identity	WASP	Non-WASP
Ethnocultural Indentification	Self-perception	Id
Projective Identification	Ideal [Woman]	
Primitive Survival Society	Civilized Survival Society	
Primitive Identity Society	Civilized Identity Society	

The road to identity is a circuitous one no doubt, but obviously an important one to travel if counselors are to "heal" themselves, or presume to heal others. Because so much attention is paid to it, and so many terms have been created to define and track it, the concept of one's identity, it would seem, is a person's primary value-referent, the ultimate direction in which, as counselors, we would presume to lead our clients. Therefore, we should have some idea of what that concept is; where it is, if stationary; or if fluid, under what guises it travels.

Weinreich (1979) quoted Erik Erikson as saying that identity formation "arised from the selective repudiation and mutual assimilation of childhood identifications," and that "children at different stages of their development identify with those part aspects of people by which they themselves are most immediately affected" (pp. 157-58).

Devereux (1975) wrote that "in order to have an ethnic identity, one must first be human. Humanness implies a capacity to be unique..."; and, "Identity is the absolute uniqueness of individual A" (pp. 42-3). What, if anything, do these statements have to do with each other? Does the second in any way obviate the first?

Devereux (1975), meanwhile, explained that individualism was part of the Athenian ethnic personality and ethnic identity model. Examined closely, this statement could be regarded as a contradiction of terms. If the preceding is a contradiction, then are identity and individuality core correspondents? Or is identity merely a conceptual seed plant, which can readily take root in other constructs such as an "ethnic personality," or in an "ethnic identity model?" If we were to presume the logical relationships in Devereux's statements from the

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viewpoint of our roles as effective counselor/therapists, should the conclusion be drawn that possession of an Athenian ethnic identity might well be an enviable achievement, or even an ideal one? Which would be really too bad for us, because all of those ancient Athenians are long gone.

It seems presumed and presumable that understanding, attaining and maintaining one's "identity" (whatever might constitute it), is the hallmark and process of achieving mental health. If that is so, must a person become, as some logical progressions might suggest, a dead Athenian, so to speak, in order to do so? Certainly there must be other, more acceptable alternatives.

Following are some definitions, or implied definitions, of identity, both individual and group (ethnic):

1. Branden (1969) related having a "strong, positive sense of personal identity" with the "sense of being a clearly defined psychological entity. A man's 'I,' his ego, his deepest self..." (p. 173).

2. Devereux (1975) believed that "Ethnic identity is neither logically nor operationally an inductive generalization from data...It is not even an ideal model. It is simply a sorting device" (p. 48). Additionally, "Ethnic identity is an all or nothing device...and sociologically, a label which can be attributed or withheld only totally" (p. 49). And finally, "...what matters is that WASP-ness is meaningful only because there also exist non-WASPS" (p.50).

3. King and Neal (1968) asserted that "Identification comes about when self-esteem is threatened. It is a defensive maneuver. The behavior of another person is initiated in phantasy or perhaps tested in reality. By identifying with another person, the subject gains a sense of power and feels that some of the objects' effectiveness in coping with disaster has been assimilated" (p. 21).

4. Glasser (1972) concluded that "In civilized survival societies (e.g., pre-A.D. 1950) most people have no identity...attaining an independent role or a human identity is impossible for most people and difficult for the remaining few" (p. 21). He also concluded that "In the new (civilized) identity society (i.g., post-A.D. 1950) few

people renounce the opportunity to struggle for an independent role...In this struggle, however, many people fail; they are unable to find a successful independent role. Although they do gain an identity, the identity is that of a failure...almost all people today try to gain an independent role. Not all, however, succeed. Many fail and identify with failure....failures involve themselves with feelings that reinforce their unsatisfactory attempt to find a successful identity" (p. 30).

As the above research indicates, the locus of identity seems to be a matter of some conjecture. And should one be having the misfortune of seeking one's own identity in Dr. Glasser's post 1950 world, it seems that his/her success would be far less than guaranteed.

Taylor and Dube (1986) summarize succinctly by writing that "establishing whether behavior is mainly under the influence of social or of personal identity is a major challenge in itself, as there is no directly observable information for discriminating between the two forms of identity" (p. 82). This summary is defended by the following scenario: A woman finds herself defending "most women's" position on an issue, even though the position of "most women" may be contrary to her personal beliefs on the issue.

Social Belonging

Taylor and Dube (1986) indicated that individuals develop some aspects of their self-concept in accordance with those social categories to which they belong. Most individuals have an integrated sense of whom they are as a person, while deriving part of their identity from a number of very different social categories, some of which may conflict with each other, and with the integrated whole. Three main strategies for achieving an integrated identity in the midst of the presence of multiple social identities are provided:

Strategy I: The individual identifies strongly with one social group. All other groups are insignificant.

Strategy II: Identification occurs with multiple social categories, but these categories share the same members; therefore, there is a reduced likelihood of identity conflict resulting from variations in norms and values.

Strategy III: The dynamic here is that the individual identifies with social categories that are similar in values. Though individuals within each category may be different, fundamental values are shared by each of the categories in question. (Taylor & Dube, 1986)

Taylor and Dube (1986) cited a 1981 study conducted by Wong-Rieger and Taylor of Francophone (French-speaking) and Anglophone (English-speaking) adults from the province of Quebec. By using a Multidimensional Scaling (MDS) formula (e.g., assuming an inverse relation between the psychological concept of similarity and the mathematical concept of distance), the study attempted to isolate ethnic identity by first asking sample respondents to each provide lists of those social categories which they thought were most contributive to their identity. Then the respondents were provided with group labels and asked to determine to what degree the label "Myself" was associated with each group label, insofar as this comparison would relate to a similarity of membership (Strategy II), as well as to a similarity of values (Strategy III).

The results of the study showed that both Francophones and Anglophones obtained a sense of identity from group associations based on a similarity of values (Strategy III). Neither study group integrated their social identities via Strategy II patterns.

Another finding of the study indicated that among Francophones, "Myself" tended to be strongly defined in accordance with group or collective values. Would this mean, then that the character of "Myself" tends, among Francophones, to assume social identities in a fashion similar to the trying on of costume items from a sale table, without reference to any higher integrative principle? And could that mean that the "Myself" of a Francophone might be progressively filtered through various, sundry and random group identities only to exit at some arbitrary point in time, in some kind of "whole?"

Anglophones, on the other hand, had a stronger tendency to avoid group labels, and assume a more individualistic orientation. And despite this finding by the study there seems to be only a matter of degrees between the relative group-identity orientation of Francophones to Anglophones. What, then, is the essence involved?

Also noted in the Taylor and Dube paper, Dube and her colleagues conducted various other studies of a nature similar to the forgoing, also using the Multidimensional scaling device. Following are some of their findings:

1. Individuals can derive a cohesive sense of self from a synthesis of their multiple social identities.

2. When conflicts arise between one's multiple social identities [women] resolve them by stressing those identities that are more closely aligned with their "ideal" self-concept.

3. When a person is evaluated on the basis of either his/her personal or social identity, it is the person's sense of "fairness" about the evaluation that determines how he or she will feel about it.

4. Sample respondents tended to react more negatively to evaluations based on their social identity versus their personal identity, regardless of the positive or negative nature of the feedback.

5. Study respondents appeared more sensitive to subtle variations in the meaning of positive feedback than negative feedback.

6. Among North Americans, a belief may exist that any judgment made on the basis of their inclusion in a given social category is inherently wrong. It seems that North Americans may regard as unfair in principle any judgment made on the basis of age, nationality, sex, etc.

7. People may make subtle distinctions in the nature of positive feedback, while reacting in a clearly negative fashion to evaluations of them based on aspects of their social identity.

8. In order to place one's self within a social context, and in order to share affinities with others while still retaining a sense of uniqueness, it seems that the individual requires a social identity component.

These conclusions and the Taylor/Dube paper as a whole may be regarded as addressing the more metaphysical sense of what they would term the individual-collective discrepancy.

Political Orientation

From what the present author would term a more political orientation (in the sense of its perspective from a point farther down on the scale of the philosophical hierarchy than the preceding), Hraba and Hoiberg (1983) give definition to the concept of ethnicity. They distinguished between old and new ethnicity, a departure point, so to speak, from the perception of the assimilationist, who saw the modernization of society and the concomitant expansion of individual opportunity and choice as the force which would weaken and obviate old ethnic organizational ties. In other words, as individual freedom advanced in society, the ethnic system would fade away in direct proportion. This "old" ethnicity equates more or less with the 18th & 19th century classical liberalism paradigm.

The new ethnicity, defined from the perspective of the pluralist, is regarded essentially as an individually defined psychological state of mind, and not the property of a group. According to the new ethnicity, the individual freedom that is available to people in modern society allows for one's ethnic identity to serve as an expression of that individual freedom. In other words, in a modern society ethnicity becomes more of a voluntary choice. And it seems, according to Hraba and Hoiberg (1983) that it is precisely individual freedom in conjunction with voluntary ethnicity that distinguishes society's alleged "mainstream" from its minorities. Minorities are cited, therefore, as being the only occurrence of involuntary ethnicity in the modern era, a point which not everyone accepts.

In her paper, Blu (1979) addressed the voluntary aspects of ethnicity, the idea that one can choose whether or not to ascribe characteristics of an ethnic identity to oneself, and in so doing, to what degree. Additionally, noting that even WASPs are coming to identify themselves, and be identified by others as falling under an ethnic banner, Blu indicated that the notion is widespread today that everyone is of an ethnic group of one kind or another. Obviously, if choice is available, the general tendency appears to be strongly toward group identification.

Comaz-Diaz and Jacobsen (1987) indicated that one's struggle to maintain his or her identity is a lifelong process, and that one's sense of self within one's culture helps to maintain self-esteem. They indicated that individuals who are in a state of cross-cultural transition are subject to additional stresses in their struggle to maintain their identity. During periods of such transition, an effort is made by the person to reintegrate his/her identity within the context of the need to accommodate the demands of the host (new) culture. There are four stages in this process:

> 1) The precultural awakening stage, consisting of poor self-esteem for one's self and minority reference group, and self-depreciation; 2) the transitional stage, characterized by withdrawal, conflicts between self-depreciation, and cultural reassessment; 3) the immersion-emersion stage, characterized by internalization of one's own cultural identity (including multiculturalism), with improved self-esteem and interpersonal relationships not restricted by race and ethnicity. (Comaz-Diaz & Jacobsen, 1987, p. 235)

The task of psychotherapy has been defined by Erikson (in Comas-Diaz & Jacobsen, 1987) as "the replacement of dysfunctional and excessive identifications with more desirable ones" (p. 235). With conflicts in ethnocultural identification, it is suggested that the therapist's job is to receive, process and mirror back to the client certain aspects of the client's "projected" compromised ethnocultural self. This essentially empathic interaction creates the basis on which the client might begin reconstruction of his/her conflicted identity. Inherent in this process seems to be the need to accept the reality (if present) of discrimination within the host society, and to relate the nature of the client's whole identity within this context.

Conclusion

On the basis of these sources for this barest of introductions to an enormously complex topic, a preliminary conclusion on the nature of identity through the therapeutic process is that perhaps in the simplest of terms, we may wander (through sexual identity, ethnicity, family roles, perhaps even through "WASP-ishness), we can never come home but that ourselves are there, knowingly waiting for us.

This may seem the most elemental of observations, but if we cannot, in the metaphysical sense, identify that essence of ourselves

and others known as our identity; if we cannot know and find the means (not to mention, the courage) to isolate, define and objectify that concept, then how can we purport--other than by crude comparison based on a kind of psychological majority rule--to properly identify dysfunction, let alone lead another to health via counseling.

Perhaps the greatest concern for counselors is that ethnicity (as a form of group identity, for example) might be regarded as a final destination, a final resting place in one's struggle for identity, self-esteem and mental health. That would leave us, metaphysically speaking, with one of two possible identity choices: "WASPness, or non-WASPness." Counselors should take care that in the healing process their premises don't restrict them to automatically leading those of us separated from "majority behaviors" in one direction only: "Back to the fold."

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